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Counselling Processes Experienced by Adult Male Survivors of Childhood Sexual Abuse

by

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Chapter 1: Introduction

Significance

Childhood sexual abuse (CSA) is a significant issue that impacts a large but often silent segment of society (Bolton et al., 1989; Finkelhor, 1984; Finkehor, 1986; Gartner, 1999; Hunter, 1990; Pierce & Pierce, 1985; Price, Hilsenroth, Petric-Jackson, & Bonge, 2001; Struve, 1990; Urquiza & Keating, 1990; Westbury & Tutty, 1999). Much of the past research in the area of CSA has been mainly devoted to female survivors; however, there are a growing number of studies focused on male survivors (Bolton, et al., 1989; Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Draucker& Petrovic, 1996; Gartner, 1999). Specifically, counselling and mental health agencies throughout North America have recently experienced increasing numbers of male clients presenting with issues associated with CSA (Day, Thurlow, & Wolliscroft, 2003; Hunter, 1990; Lab, Feigenbaum, & De Silva, 2000; Lew, 1990). Although prevalence rates of male CSA are varied, estimates range from 3% to 37% and have been reported as high as 76% (Bagley, Wood, & Young, 1994; Coxell, King, Mezey, & Gordon, 1999; Dhaliwal et al., 1996; Finkelhor, Hotaling, Lewis & Smith, 1990; Holmes & Slap, 1998). It has been argued that that the lowest estimates are likely a reflection of under-reporting (Etherington, 1995; Gill & Tutty, 1997; Romano & DeLuca, 2001). Given the high rate of CSA, it is likely that helping professionals will, at some time, work with adult male survivors of CSA (Cahill, Llewelyn, & Pearson, 1991; Collings, 1995; Day et al., 2003; Hibbard & Zollinger, 1990; Lab et al., 2000).

While a large portion of the male population has experienced CSA, male survivors tend to underreport the abuse and are less likely to seek professional help to

deal with the related abuse issues (Dorais, 2002; Harrison & Morris, 2001; King, Coxell & Mezey, 2000). Numerous factors have contributed to the under-reporting of male CSA. Historically, male CSA was believed to be an infrequent occurrence and did not have a significant impact on later development (Crowder, 1995; Hunter, 1991). Dhaliwal et al., (1996) added that many mental health professionals may have denied the existence of male sexual abuse, may have been reluctant to deal with male survivors, or may have minimized the negative effects of male sexual abuse.

Many researchers have postulated that male socialization patterns are associated with survivors' hesitancy in reporting and dealing with the aftermath of CSA (Dimock, 1988, Etherington, 1995; Mendel, 1995; Romano & De Luca, 2001; Harringt, 1996; Hunter, 1990; Struve, 1990). Although societal expectations have changed for men over the last few decades, many men may still feel strong societal pressure to conform to specific gender role conceptions (Dorais, 2002; Romano & De Luca, 2001). Societal norms often promote the idea that men are to be self-reliant, independent, powerful, competitive, aggressive, dominant, in control, emotionally restrictive, able to protect themselves from violations by others, and consistently initiate and welcome sexual experiences (Struve, 1990). This socialization process often creates a situation in which male children and adults are reluctant to report the abuse, as it may result in them being perceived as lacking in masculinity. Another concern is a fear of being blamed, particularly if survivors felt any sense of arousal during the abuse (Etherington, 1995). In addition, male survivors may associate the sexual abuse with homosexuality, which may be further exacerbated by societal homophobia (Etherington). Since male CSA is under-reported, a need exists for helping professionals to gain an understanding of these

socialization factors in order to provide appropriate and effective treatment (Dhaliwal, et al., 1996).

Definition

A complication inherent in the study of CSA is the myriad of definitions utilized to describe this phenomenon (Holmes & Slap, 1998). Researchers have noted that few studies in this area have employed consistent definitions (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Bolton, Morris, & MacEachron, 1989; Draucker, 1992; Fater & Mullaney; Fergusson, & Mullen, 1999; Gartner, 1999). Fater et al., (2000) have considered CSA as a type of abuse that involves developmentally inappropriate or coercive sexual contact. Others have described CSA as a range of behaviors involving contact or non-contact of a sexual nature perpetrated by an individual at least five years older than the child (Bolton et al., 1989). Contact abuse has been described as a chargeable crime and entails physical contact (i.e., penetration, stimulation etc.) (Gartner, 1999). Non-contact abuse on the other hand, is a broad term addressing a wide range of sexual behaviors such as: sexualized talk, practicing voyeurism, photographing a child for sexual purposes, exposing a child to pornographic material, masturbating or otherwise being sexual in front of the child, and exposing genitals to child (Gartner, 1999; Hunter, 1990). Given the lack of a uniformly accepted classification of CSA, researchers in this current study have described CSA based on the existing literature exploring this complex definition (Beitchman et al., 1992; Bolton et al., 1989; Garnter, 1999; Hunter, 1990; Wilken, 2003). For the purposes of this project, CSA is any act of a sexual nature, involving contact and/or non-contact, imposed by a perpetrator upon a child where there is an imbalance of power and control. While a perpetrator can be an adult (i.e., parent or

family friend), CSA can also occur under conditions in which the child and perpetrator are similar in age and a power imbalance and control is present, such as within sibling and peer relationships (Gartner, 1999).

Treatment Issues

Much of what is experienced by male survivors of sexual abuse often extends beyond the initial incident of abuse and results in long-term psychological maladjustment (Dhaliwal et al., 1996; Mullen, Martin, Anderson, Romans, & Herbison, 1995). Numerous studies have indicated that CSA experienced by males often has a negative impact on later adult functioning and is associated with post-traumatic stress disorder, anxiety disorders, intense anger, diminished self-esteem, interpersonal difficulties, suicidal tendencies, disordered eating behaviors, sexual risk taking, substance abuse, feelings of alienation, distorted body image, internalized homophobia, sexual orientation ambiguity, self-blame and shame (Abdulrehman & De Luca, 2001; Beitchman et al.,1992; Briere & Runtz, 1993; Cahill, Llewelyn & Pearsons, 1991; Chandy, Blum & Resnick, 1997; Collings, 1995; Dhaliwal et al., 1996; Etherington, 1995; Finkelhor, 1990; Gill & Tutty, 1997; Herman, 1997; Mullen et al., 1995; Myers, 1989; Ray, 2001; Romano & De Luca, 2001).

Despite the psychological consequences of CSA, research has pointed out that only a minority of these individuals who need mental health and counselling services actually seek assistance from trained professionals (Harrison & Morris, 2001). Considering the significant aftermath associated with CSA, it is important to explore the therapeutic processes which may alleviate the psychological impact of CSA on male survivors.

Literature regarding the treatment of CSA has suggested that there is no treatment of choice (Nurcombe, Wooding, Marrington, Bickman, & Roberts, 2000; Saywitz, Mannarino, Berliner, & Cohen, 2000). Studies have reviewed the effectiveness of numerous treatment approaches designed for survivors of CSA including cognitive behavioral therapy, emotion focused therapy, integrative therapy, and feminist based treatments (Clark & Llewelyn, 1994; Jehu, Klassen & Gazan, 1986; Paivio & Nieuwenhuis, 2001; Stalker & Fry, 1999). Overall findings suggest that both individual and group therapy can be beneficial for survivors (Price et al., 2001). Although studies examining treatment modalities for CSA have been informative, they have mainly focused on female survivors; thus, limiting the ability to generalize these findings to males. Treatment approaches designed for male survivors may need to be individualized, as no one treatment has been shown to be most effective (Nurcombe et al., 2000; Saywitz et al., 2000).

Research exploring psychotherapy process has been typically concerned with the therapists' view of therapy (Garfield, 1995; Hill & Alexander, 1993; Orlinsky, Ronnestad, & Willutzki, 2004; Paulson & Worth, 2002). Increasingly, researchers are acknowledging that the client's perspective of therapy can amplify our understanding of psychotherapy process (Heppner, Rosenberg, & Hedgespeth, 1992). Furthermore, studies have identified that clients' perceptions of therapy often differ from therapists' view point (Bachelor, 1991; Elliot & James, 1989). Although research attention has been directed towards understanding the client's perspective of therapy, little is known about how male survivors experience counselling.

Purpose of this Study

Holmes & Slap (1998) conclude "the sexual abuse of boys is common, underreported, under-recognized and under-treated" (p. 1860). This study intends to enhance our understanding of the counselling process as perceived by male survivors of CSA. As the research literature clearly demonstrates that male survivors do not readily seek counselling (Harrison & Morris, 2001), it is important to identify what motivates them to engage in therapy. Additionally, the clients' perspective can richly enhance our conceptual awareness of what is helpful and unhelpful in counselling (Heppner et al., 1992). Therefore, an additional purpose of this study is to describe the key therapeutic aspects involved in the counselling process from the male survivor's perspective. The questions guiding this research include:

1) What motivated male survivors to seek counselling?
2) What aspects of counselling made a difference for male survivors dealing with childhood sexual abuse?
3) What would male survivor change about their counselling experience?

To explore how male survivors of CSA perceive counselling, the methodological approach of concept mapping was used. Concept mapping is applied to the current study in order to gain an understanding of how male survivors experience the underlying structures of the counselling process (i.e., motivating factors, helpful and unhelpful therapeutic elements). Cultivating an appreciation of the male survivors' perspective of therapy is important, as it can inform and contribute to what is known about psychotherapy process.

Chapter 2: Literature Review

Introduction

Prior to undertaking this research study, an in-depth examination of the existing literature in the areas of male survivors of childhood sexual abuse (CSA) and psychotherapy research was completed. In gaining a thorough understanding of these areas, a number of related topics were explored. Firstly, a conception of the problem of CSA was acquired through a brief overview of the prevalence research. Secondly, literature regarding the particular effects of CSA in adulthood and the treatments available for survivors were surveyed. Thirdly, psychotherapy outcome and process research with particular attention to the helping and hindering processes in therapy were reviewed. Fourthly, literature concerning client and therapists perspectives on therapy was explored. To conclude the review, a discussion regarding the implications of the existing literature for this study was presented.

Prevalence Studies of Childhood Sexual Abuse

Childhood sexual abuse is an issue that has received considerable attention since the mid 1970's and early 1980's (Gartner, 1999; Hunter, 1990). Numerous studies have investigated the prevalence of CSA and have generated an awareness of this significant societal issue (Bagley et al., 1994: DeJong, Hervada & Emmett, 1983; Dhaliwal et al., 1996; Dimock, 1988; Finkelhor, 1984; Holmes & Slap, 1998; Hunter, 1990; Jones, Finkelhor, & Kopiec, 2001; Peters, Wyatt & Finkelhor, 1986; King, Coxell, & Mezey,2000; Risin & Koss, 1987; Russel, 1986; Sarafino, 1979; Wurr & Patridge, 1996; Wyatt, 1985). While there has been a considerable amount of research done in the area of CSA, much of this literature has focused on female survivors (Bolton et al., 1989;

Briere, Evans, Runtz, & Wall; 1988; Dhaliwal et al. 1996; Draucker & Petrovic, 1996; Fater & Mullaney, 2000; Gartner, 1999; Gold et al., 1999; Hunter 1990; Ray, 2001; Swift, 1980). Although the sexual abuse of males had been considered to be rare (Hunter, 1991) since the mid 1980's, there has been a growing recognition of the existence of male CSA (Dhaliwal et al., 1996; Harrison & Morris, 2001). At the forefront of investigating the prevalence rates of CSA are Finkelhor et al., (1990), Bagley et al., (1994), and Risin & Koss (1987).

In the first national prevalence study of CSA, Finkelhor et al. (1990) found that 27% of women and 16% of men surveyed had a history of CSA. This study not only provided a national estimate of the prevalence of CSA among both male and female adults, but also confirmed previous studies done at the regional level in the United States.

Prevalence rates and the associated effects of male CSA were investigated in a subsequent Canadian survey (Bagley, et., al, 1994). A total of 750 adult males, ages 18 to 27, were recruited for the study employing a stratified random sample. Results indicated that 15.5% (n= 117) had experienced unwanted sexual contact before the age of 17. Participants who reported multiple events of sexual abuse (6.9%) were found to be statistically different from other participants in that they had higher rates of depression, anxiety, suicidal feelings and behaviors, and had experienced emotional abuse in childhood.

A nationwide survey conducted in the United States was specifically directed towards obtaining prevalence estimates of male CSA (Risin & Koss, 1987). Self-report accounts of CSA experiences before the age of 14 were obtained from 2972 men. Abusive experiences were defined in terms of three criteria: (1) age discrepancy; (2) use

of coercion; (3) authority or care-giver role status of the abuser. Results indicated that 7.3% of men reported a childhood sexual experience that qualified as abusive according to the studies three criteria. Although it is arguable that this sample was not representative of the general population, Risin and Koss argued that at that time this group represented 26% of all persons in the United States aged 18 to 24 (1987).

In a fairly recent study examining a non-clinical male population Lisak, Hopper, and Song (1996) surveyed nearly 600 college men. Based on the participant responses, the researchers categorized the participants into three groups: (1) men with histories of CSA; (2) men with histories of physical abuse; and (3) men who experienced both sexual and physical abuse. Findings indicated that in their sample, one in six men (18 %) reported direct sexual abuse by the age of 16.

Coxell, King, and Gordon (1999) also conducted a study designed to identify the lifetime prevalence of non-consensual sexual experiences in men. The study took place in England and was conducted in 18 general practice medical offices. Interviews were conducted utilizing a private computer system. Of the 2474 men who agreed to participate in the study, 5.35% reported non-consensual sexual experiences as children. Additionally, 7.66% of male participants reported that they had experienced what they perceived to be consensual sexual experiences as children. It is important to note that the experiences deemed by male participants to be of a consensual nature, were nonetheless considered to be illegal under English law. Coxell et al., (1999) concluded that given the rates found in this study, medical professionals are likely to encounter male patients who have experienced non-consensual sexual experiences in their childhood.

Interestingly, recent studies regarding the prevalence of CSA have indicated that there has been a possible decrease in the cases substantiated by child protective agencies (Jones, Finkelhor & Kopiec, 2001). According to estimates from the National Child Abuse and Neglect Data System (NCANDS), cases of substantiated sexual abuse declined approximately 39% nationwide from 1992 to 1999. Child protection services (CPS) administrators in the United States were interviewed in regards to their knowledge of the decreasing trend and the potential state-level factors contributing to the decline. It was noted that the cases in which were reported to CPS were only a minute representation of the true occurrence of CSA (Jones et al., 2001; Leventhal, 2001). Findings suggested that over 50% of the CPS administrators indicated that the decline in cases of substantiated sexual abuse was likely due to procedural changes and reporting behaviors, rather than an actual decline in occurrence.

Considering the research literature on the prevalence of male CSA, it appears that there is a wide variability in reported rates. Specifically, past findings regarding prevalence rates for CSA have ranged from 2.5% to 36.9 percent (Dhaliwal et al., 1996). Holmes and Slap (1998) reviewed 166 studies and found that the prevalence estimates of sexually abuse boys ranged from 4% to 76%. According to the study by Jones et al (2001), it appears that there has been a recent 39% decline in substantiated CSA. Given the substantially varying prevalence rates, it is difficult to determine, with any amount of precision, the actual occurrence of male CSA.

There are a number of possible variables contributing to the discrepancy in prevalence rates. For instance, evidence suggests that there is a significant underreporting of CSA cases involving male survivors (Etherington, 1995; Romano & DeLuca, 2001).

Researches have noted that there are roughly three to four times as many cases of sexual abuse than are actually disclosed or reported (Crowder, 1995; Violato & Genuis, 1993).

The evident difficulty in evaluating prevalence studies for male survivors is further explored by Mendel (1995). Mendel (1995) and others researchers have cited the presence of methodological discrepancies in studies (Finkelhor, 1986; Holmes & Slap, 1998; Hunter, 1991). In particular, differences in sample selection and the varied definitions of sexual abuse have been identified as influencing the variance in prevalence rates (Mendel, 1995).

In addition to the methodological concerns and the underreporting of CSA, there are issues particular to male survivors that may also attribute to the discrepancy in prevalence rates. Silence, shame, and male socialization patterns have been identified as some of the potential reasons for the underreporting of male CSA (Dhaliwal et al., 1996; Dimock, 1988; Etherington, 1995; Harrison & Morris, 2001; Romano & DeLuca, 2001). The traditional conception of the stereotypical male has been thought to be associated with a male survivor's reluctance in disclosing his experiences of vulnerability and sexual victimization (Hunter, 1991; Struve, 1990). When males do disclose it is often after many years of silence (Harrison & Morris).

A study by Bagley et al., (1994) found that male survivors who experienced multiple incidents of sexual abuse, felt too ashamed, felt partly responsible, were scared of the abuser, or were too attached to the abuser as reasons for not reporting the abuse. In cases when the abuse was disclosed, no intervention led to the prosecution of the abuser (Bagley, et al., 1994). Given that a significant number of males may wait until adulthood

to deal with their experiences of CSA, it is imperative that professionals in the helping field are sensitive to the potential issues specific to this population.

Effects of Childhood Sexual Abuse

Increasingly, there is an awareness and recognition of male sexual abuse as a serious societal issue with potentially several negative after-affects (Romano & DeLuca, 2001). Numerous researchers have explored the aftermath of CSA (Abdulrehman & De Luca,2001; Beitchman et al., 1992; Briere , Evans, Runtz, & Wall, 1988; Briere & Runtz, 1993; Cahill et al.,1991; Collings, 1995; Dimock, 1988; Draucker& Petrovic, 1996; Dhaliwal et al., 1996; Fater & Mullaney, 2000; Gill & Tutty, 1997; Gold, Lucenko, Elhai, Swingle & Sellers, 1999; Hunter, 1991; King, Coxell, & Mezey, 2002; Mullen et al., 1996; Myers, 1989; Nurcombe, 1999; Olsen, 1990; Pierce & Pierce, 1985; Ray, 2001; Urquiza & Capra, 1990). Kendall-Tackett, Williams, & Finkelhor (1993) reviewed 45 empirical studies on the initial impact and effects of CSA on male and female children. Those who had experienced CSA exhibited a myriad of negative effects, including post-traumatic stress disorder, lower self-esteem, withdrawal, depression, delinquency, aggression, sexually inappropriate behavior, self-injurious behavior, and nightmares.

The initial effects of CSA may also extend into adulthood (Romano & De Luca, 2001). The literature on the long-term effects of CSA suggests the presence of several interpersonal and social difficulties in adulthood (Abdulrehman & De Luca, 2001; Beitchman et al., 1992; Cahill et al., 1991; Fergusson & Mullen, 1999; Mullen et al., 1996). Childhood sexual abuse has been linked to anxiety, depression, low-self esteem, sexual difficulties, suicidal ideas, and impaired social behavior (Abdulrehman & DeLuca, 2001; Beitchman et al., 1992; Mullen, Martin, Anderson, Romans, & Herbison, 1993;

Cahill et al., 1991). Furthermore, Beitchman et al., (1992) also reported that variables such as duration of abuse, presence of penetration, and perpetrator identity increased the likelihood of long-term consequences experienced by survivors.

Despite the existing literature regarding the long-term effects of CSA in adulthood, a statistical association does not necessarily indicate a causal relationship (Fergusson & Mullen, 1999). Mullen (1993) claims that the effects and impact of CSA varies for each individual depending on the severity of the abuse and the developmental history of the child. In addition, Fergusson and Mullen (1999) contend that individuals who experience CSA do not show one common syndrome, but instead are characterized by potentially having a heightened vulnerability to a wide variety of mental health issues. Nurcombe et al., (2000) argue that family functioning (i.e., emotional neglect, marital difficulties, parental substance abuse, and parental psychopathology) prior to the abuse can have an impact in how CSA is processed and dealt with. As purported by Mullen (1993), "Abuse is not destiny, but it does make progress toward successful, social, interpersonal, and intrapsychic functioning in life more difficult" (p. 431).

Given that the effects of CSA are often particular to the individual, a number of studies have compared the aftermath for both females and males (Briere et al., 1988; Hunter, 1991; Finkelhor, 1990; Finkelhor et al., 1990; Gold et al., 1999; Pierce & Pierce, 1985). A study investigating the symptomology of males and females sexually abused as children found few differences in a clinical population of survivors (Briere et al., 1988). Forty male and 40 female sexual abuse clients recruited from a crisis centre completed the Trauma Symptom Checklist (TSC-33). Findings suggested that a history of CSA was associated with later psychological difficulties in both male and female clinical

populations. In addition, compared with non-abused individuals, both male and female survivors reported significantly more difficulties in the areas of anxiety, depression, anger, sleep, and dissociation. These findings were later confirmed by other researchers who also found relatively similar abuse-related problems in male and female adult survivors (Finkelhor et al., 1990).

While some studies have found no significant differences in the long-term effects of CSA in males and females, there has been evidence suggesting some subtle gender differences. Hunter (1991) examined the long-term psychosocial maladjustment of adult male and female survivors. In this study, a matched number of non-clinical samples of males and females were compared with a control group on a variety of outcome measures. Results supported the link between CSA and later adult psychosocial difficulties in both males and females. Furthermore in comparing the two groups, it appeared that male survivors experienced heightened levels of anxiety, worry, and rumination as it related to issues of identity confusion. Hunter (1991) also reported that male survivors frequently suffered from extreme doubts about their masculinity, particularly when the perpetrator was of the same sex.

A recent study also compared the psychological and psychiatric symptomatology of male and female survivors (Gold et al., 1999). Participants consisted of men and women in an outpatient treatment program for adult survivors of CSA. Symtomatology was measured by the Symptom Checklist 90-Revised (SCL-90-R). Results indicated that male survivors exhibited significantly more interpersonal sensitivity, depression, anxiety, and phobic anxiety. It is evident that although data generally suggests that there are more similarities than differences between the sequelae of CSA in males and female, there are

potentially specific characteristics attributed to the male experience (Etherington, 1995; Gill & Tutty, 1997; Gold et al., 1999; Hunter, 1991).

Research investigating the particular effects of male CSA in adulthood has increased significantly (Romano & De Luca, 2001). An early study conducted by Dimock (1988) investigated the effects of sexual abuse on a male clinical sample (N = 25). The presence of three common experiences were evident: (1) sexual compulsiveness; (2) masculine identity confusion; (3) relationship dysfunction. Dimock (1988) suggested the need for treatment to address these male specific aspects associated with CSA.

Romano and De Luca (2001) recently surveyed the literature examining the issues commonly experienced by male survivors. In particular, some of the short-term and long-term effects associated with male sexual abuse were explored. These effects included depression, guilt, self-blame, low self-esteem, anger, anxiety, and sexuality problems. Many of the conclusions made by Romano & De Luca (2001) confirm previous studies investigating the consequences linked to male CSA (Bagley et al., 1994; Beitchman et al., 1992; Briere et al., 1988; Finkelhor et al., 1990; Gold et al., 1999; Hunter, 1991; Urquiza & Capra, 1990).

Qualitative accounts have provided an insightful view of the aftermath and the recovery process of CSA from the male survivors' perspective (Draucker & Petrovic, 1996; Etherington, 1995; Fater & Mullaney, 2000; Gill & Tutty; Ray, 2001). Draucker & Petrovic (1996) employed qualitative methodology to gain an in-depth understanding of the healing process experienced by male survivors. One of the most striking findings reflected the participants' experience of healing as "escaping the dungeon". Essentially, the metaphor of the "dungeon" referred to the participants' experiences of powerlessness,

isolation, shame, silence, and pain from their abuse. Healing was described as "breaking free" and "living free".

A study conducted by Ray (2001) explored male survivors' perceptions of the consequences of CSA. Participants indicated having difficulties in the areas of social, psychological, emotional, physical, and sexual functioning, as well as, interpersonal relations and self-esteem. These results confirm both previous quantitative and qualitative work investigating the aftereffects of CSA in the male population (Draucker& Petrovic, 1996; Etherington, 1995; Fater & Mullaney; Gill & Tutty, 1999).

Treatment of Childhood Sexual Abuse

Given the absence of any single set of reactions or aftereffects experienced by survivors of CSA, treatment becomes largely an individualized process designed to meet the needs of the particular client (Cahill et al., 1991; Mannon & Leitschuh, 2002; Nurcombe et al., 2000; Saywitz et al., 2000). A number of treatment modalities have been applied both in childhood and adulthood and have received considerable attention (Armsworth. 1989; Bruckner & Johnson, 1987; Carver, Stalker, Stewart & Abraham, 1989; Chard, Bennett, Hall, 1997; Clarke & Llewelyn, 1994; Dimock, 1988; Finkelhor & Berliner, 1995; Harrison & Morris, 2001; Jehu et al.,1986; Morgan & Cummings (1999); Paivio & Nieuwenhuis, 2001; Stalker & Fry, 1999; Talbot, Houghtalen, Duberstein, Cox, Giles, & Wynne, 1999; Westburry & Tutty, 1999; Winder, 1996).

Finkelhor and Berliner (1995) conducted a thorough review of the empirical literature available on the treatment of child sexual abuse. A total of 29 studies employing pre- and post- standardized measures were examined. The focus of the studies was primarily on the assessment of change in the sexually abused child or parent

following treatment. Among the studies reviewed, 13 involved female participants; 2 consisted of only male participants; and the remaining 14 studies included both males and females. The treatment methods employed in these 29 studies included, family therapy, individual or group cognitive-behavior therapy, psychodynamic individual psychotherapy, music therapy, drama therapy, crisis intervention, non-directive therapy, and other unspecified treatment approaches. Regardless of the particular intervention, improvements were found in a number of areas including PTSD symptoms, sexually inappropriate behaviors, internalizing and externalizing behaviors. Results suggested that symptoms experienced by children who have been sexually abused were responsive to professional intervention.

A pre- and post study was conducted on a pilot treatment approach designed for adult survivors of CSA (Smith et al., 1995). Treatment included the provision of a therapist and ancillary support services designed to meet the needs of adults who experienced CSA. A total of 89 male and female participants completed three psychological questionnaires both at the beginning and end of treatment. Findings indicated that participants who received the specialized therapy approach showed a marked decrease in clinical distress scores. While this study did not employ the methods of systematic randomization to treatment and control groups nor did it incorporate a comparison group, it appears that participants' symptomatic states improved in the short-term.

Overall, the literature has highlighted the importance of treatment for survivors to be individualized and multifaceted (Harrison & Morris, 2001; Mannon & Leitschuh, 2002; Nurcombe et al., 2000; Gartner, 1999). As postulated by Gartner (1999), one of the

fundamental needs of an individual who has experienced CSA is to gain the capacity to relate to others in a more functional way. Gartner (1999) stresses that a male survivor, in particular, is in need of a helping relationship that facilitates the survivor to let himself be known to the other person. Researchers have proposed that individual psychotherapy is an avenue for male survivors to cultivate interpersonal understanding and to explore issues related to their experiences of CSA (Bolton et al,, 1989; Dimock, 1988; Gartner, 1999; Mezey & King, 2000).

Research on Individual Psychotherapy Outcome Studies

Limited work has been done in relation to individual psychotherapy outcomes for survivors of CSA. In particular, research evaluating psychotherapy with male survivors is scant in comparison to female survivors. Given the lack of psychotherapy research specifically focused on male survivors, such information will be extrapolated from research primarily done with female survivors.

Jehu et al., (1986) conducted a study utilizing a cognitive-behavioral (CBT) model intervention for 11 female adult survivors of CSA. The primary objective of this treatment modality entailed correcting distorted beliefs associated with CSA and the alleviation of any accompanying mood disturbances. Findings indicated a clinically significant change in clients' level of distorted beliefs and levels of depression. Despite some methodological limitations (i.e., lack of control group, lack of multiples raters), it appears that this early study highlighted some of the potential benefits of CBT for survivors of CSA (Price et al., 2001).

Clark & Llewelyn (1994) conducted a study investigating a cognitive analytic therapy (CAT) treatment approach for adult female survivors of CSA. This therapeutic

modality was described as involving "a collaborative reformulation of clients' difficulties in terms of traps, snags, and dilemmas experienced by the client and manifested in neurotic or maladaptive patterns of behavior" (p. 276). Treatment strategies in CAT included cognitive restructuring, reprocessing of nightmares, assertiveness training, and most importantly, the interpretation of transference and counter-transference. Findings revealed a significant decrease in depression, self-abusive behavior, distorted beliefs, and other symptomatic distress. Improvements were also sustained three months after therapy.

Stalker & Fry, (1999) compared the effectiveness of group therapy and individual therapy designed for 86 female adult survivors of CSA. Both treatment conditions entailed a total of 10 sessions rooted on a feminist understanding of CSA. Post-treatment results indicated that participants had fewer symptoms of trauma and post-traumatic stress, reported feeling less shame and responsibility, and experienced enhanced psychosocial functioning. Upon the 6-month follow-up, decreases in symptomatic distress remained stable and after a 12-month period had decreased significantly. Results of this study suggested that regardless of therapeutic context (i.e., group or individual), this treatment modality was valuable and can had significant long-term impact.

A recent study examined the effectiveness of Emotion Focused Therapy for Adult Survivors (EFT-AS) with 32 female survivors of childhood sexual, emotional, and physical abuse (Paivio & Nieuwenhuis, 2001). Participants were assigned to EFT-AS therapy or to a delayed therapy condition. The EFT-AS treatment approach was grounded on current emotion theory and experiential therapy theory and research. The expression of affect and corrective emotional and relational experiences was the primary focus.

Findings from this study supported the efficacy of EFT-AS as a beneficial treatment approach for adult survivors of childhood abuse. Participants in the treatment group reported statistically and clinically significant improvements in self-affilitation, interpersonal difficulties, and overall abuse related symtomatology. Additionally, treatment gains were sustained 9-months post-therapy.

Price et al., (2001) also reviewed individual psychotherapy outcomes for adult survivors of CSA. In this review, a total of 8 studies were included (Jehu al., 1986; Chard, Bennett, & Hall, 1997; Clark & Llewelyn, 1994; Paivio & Bahr, 1998; Paivio & Nieuwenhuis, 2001; Paivio & Patterson, 1999; Smith et al., 1995; Stalker & Fry, 1999). A number of conclusions were made based on an in-depth review of the numerous studies reviewed. For instance, across the different therapeutic orientations several significant improvements were illustrated. Several methodological limitations were also noted among the various studies (i.e., an absence of detailed sample descriptions, insufficient information on clinical diagnoses or comorbidity, lack of blind evaluations, limited use of comparison groups, and lack of treatment adherence). Despite these methodological concerns, Price et al., (2001) suggested that the empirical data available supported the use of individual psychotherapy for adult survivors of CSA.

Helpful and Hindering Aspects of Individual Therapy

Gaining an understanding of what is found to be helpful and hindering in therapy can be useful in understanding the therapeutic process. Elliot (1985) conducted a study designed to develop an empirical taxonomy for helpful and non-helpful counselling events based on clients' descriptions of immediate therapeutic impact. Immediate therapeutic impact was defined as "the immediate effects on the client of specific

counsellor responses (Elliot, 1985, p. 307). A total of 86 helpful and 70 non-helpful counsellor responses were identified and described by the participants. Results indicated eight categories of helpful events, which were grouped into two "superclusters". The two "superclusters" consisted of aspects relating to task and interpersonal aspects of the helping interactions. Specifically, in the task cluster, the predominant helpful feature was "new perspective" and in the interpersonal cluster, the main helpful aspect was "understanding". New information gained in the sessions resulted in increased insight, awareness, or cognitive restructuring. Additionally, understanding events were typified by participants' feelings that the therapist accurately understood them and was compassionate to their situation. Six kinds of non-helpful events were also identified, the most common being "negative counsellor reaction", "unwanted responsibility", and "misperception". Although the generalizability of this study is limited as the sample population consisted of college students, the findings provided groundwork for other research to be done in this area.

In the late 1980's Elliot and James (1989) conducted a comprehensive analysis of the main themes evident in the literature dealing with clients' experiences of therapy. It was noted that clients identified two major helpful elements inherent in individual therapy: (1) task/problems solving aspects; and (2) relationship/affective aspects. The task/problem solving aspect consisted of subcategories pertaining to the clients' perceptions of self-understanding, and the therapist's encouragement of gradual practice. The relationship/affective aspect referred to the following three subcategories: (1) facilitative therapist characteristics; (2) client self-expression; and (3) the experience of a supportive relationship. Elliot and James (1989) claimed that there were limitations of the

review, as there was a reliance on indirect measures of client experience and on instruments and coding schemes not specifically designed to explore client perspectives.

In a later study investigating the helpful and hindering processes in client-centered/experiential therapy, both clients and therapists perceptions were explored (Lietaer, 1992). During the course of therapy, therapists and clients completed post-session questionnaires every other session. Results of the study indicated three categories relating to helpful processes in therapy: (1) aspects of the relational climate (i.e., empathy and acceptance); (2) specific therapist interventions (i.e., feedback, confrontation, and self-exploration); and (3) process aspects concerning the client (i.e., experiencing feelings and insight). It is interesting to note that there appeared to be a difference in what clients and therapists perceived to be most helpful. For instance, clients (21%) more than therapists (10%) viewed the relational aspect of therapy as helpful. In terms of the hindering aspects of therapy, two main categories were found: (1) therapist's attitudes and interventions; and (2) client processes. Considering the clients' perspective, it appeared that the first category pertained to the therapists' behavior and clients' negative perceptions of the relationship. The second group was characterized by the client behaviors and negative reactions to the therapeutic process. Overall, Lietaer (1992) noted that both clients' and therapists' descriptions of the hindering aspects of therapy were often in regards to a missed opportunity or transitory moment that were experienced as difficult in an otherwise positive session.

Paulson, Truscott, and Stuart (1999) explored clients' perceptions of helpful experiences in counselling. Five thematic clusters were generated using the concept mapping approach: (1) counsellor facilitative interpersonal style; (2) counsellor

interventions; (3) generating client resources; (4) new perspectives; and (5) client self-disclosure. Participants also identified four additional thematic categories: (1) emotional relief; (2) gaining knowledge; (3) accessibility; and (4) client resolutions. It appeared that the role of the therapist's interpersonal style and the therapeutic relationship emerged as especially helpful elements of the counselling experience. Furthermore, the participants' ability to self-disclose was rated as the most helpful aspect in therapy. Additionally, participants identified the ability to release and express emotions as highly important in the counselling process. Participants' ability to achieve a desired outcome and gain new interpersonal knowledge was also perceived as helpful. The findings of this study highlighted the multifaceted aspects of helpful experiences in counselling as perceived by clients.

A subsequent study by Paulson, Everall & Stuart (2001) investigated client perceptions of hindering experiences in counselling. Three main hindering aspects of counselling were identified: (1) counsellor behaviors (e.g., insufficient counsellor directiveness), (2) external and structural barriers (e.g., counsellor availability and accessibility), and (3) client variables (e.g., lack of commitment and motivation). It is important to note that while participants identified hindering aspects of their counselling experiences, they reported that these aspects were interfering rather than preventative of a positive outcome.

Apart from the work exploring helpful and hindering experiences in general counselling populations, studies have also focused on survivors of CSA (Armsworth, 1989; Bonney, Randall, & Cleveland, 1986; Carver, Stalker, Stewart and Abraham, 1989; Pudmoreoff, 1997; Wheeler, O'Mally, Waldo, Murphey, & Blank, 1992). Although these

studies have contributed to the understanding of female survivors' experience in counselling, very little attention has been focused on male survivors' perspectives.

Armsworth (1989) completed a study examining the self-reports of 30 female adult survivors of CSA and their perceptions of helpful and harmful aspects of therapy. Participants identified several conditions or practices as helpful: (1) validation; (2) advocacy; (3) empathetic understanding; and, (4) absence of contempt, punishment or derision. Additionally, four interventions were considered to be of little help or caused harm: (1) blaming the client; (2) lack of validation; (3) negative or rejecting responses: and, (4) exploitation of the client. This preliminary study was fundamental in understanding the perceptions of what clients with a CSA history, identified as helpful and harmful in their counselling experience.

Client and Therapist Perceptions of Therapy

Often the perceptions of clients and therapists differ in regards to the counselling process (Bachelor, 1991; Caskey, Barker, and Elliot, 1988; Elliot & James, 1989; Elliot & Shapiro, 1992; Grafanaki & McLeod, 1995; Heppner et al., 1992; Llewelyn, 1988). Llewelyn (1988) explored the perspectives of 40 therapist-client dyads. After each session, both the therapists and clients were asked to complete a questionnaire intended to obtain their views concerning the helpful and unhelpful events which occurred during the session. Upon termination of therapy, dyads were asked to describe their retrospective views of the helpful and unhelpful events and to report an outcome. Results indicated that clients valued reassurance and relief most during therapy. Upon therapy termination, clients emphasized the problems-solving aspects of therapy as being helpful. In contrast, therapists frequently reported cognitive and affective insight both during and after

termination. According to therapist reports, unhelpful confrontation and misdirection were most frequently reported as unhelpful aspects during and after therapy, respectively. Clients on the other hand indicated that the aspect of disappointment was most unhelpful both during and upon therapy termination. These findings highlighted the apparent differences in client and therapist perspectives of helpful and unhelpful factors in therapy.

Heppner et al., (1992) examined the therapeutic process by employing three methods that focused on (1) how clients interpret the change process and counsellor behavior over the course of therapy; (2) the content of clients' and counsellors' most memorable thoughts immediately after the session; and, (3) the comparison of clients and counsellors most memorable thoughts with the actual content of the counselling sessions. One of the most striking results of the study illustrated the qualitative differences in how clients and counsellors process of their experience of counselling. Specifically, a high proportion of negative client thoughts persisted during therapy (i.e., negative cognitions regarding counsellor-client relationship, themselves, and the therapy experience). The frequency of negative client thoughts was notably contrasted with positive counsellor ratings. It appeared that both clients and counsellors were constructing and interpreting the counselling experience differently.

In a study of female survivors of CSA conducted by Pudmoreoff (1997), the perspectives of three counsellor-client dyads were explored. A phenomenological approach was employed to gain an in-depth understanding of therapy with this particular population. Findings illustrated that both clients and therapists viewed effective therapy as involving a number of essential aspects: a client who is motivated, a genuine therapist, a view of the counselling experience as a joint venture or collaborative process,

unconditional acceptance, continual validation, compassion, respect, safety, and trust. Although congruencies between client and therapist perspectives were evident, notable discrepancies were also found. Clients placed more emphasized on the need for therapists to be genuine, whereas, therapists placed particular value on the need for clients to be motivated. In addition, clients' regarded therapist availability, as well as issue containment and closure as significant. While the therapists were aware of these important elements, they did not emphasize their importance to the same degree. Instead, therapists emphasized the value of rediscovering the client's voice and of maintaining therapist integrity.

Implications of the Research Literature

Given the significant prevalence and long-term effects of CSA, it is likely that male survivors will need therapeutic services (Day, Thurlow, & Wooliscroft, 2003; Lab, Feigenbaum & De Silva, 2000). While a considerable amount of research attention has been focused on examining prevalence rates and the aftermath associated with male survivors, little work has explored the counselling experience as perceived by this client population (Hill & Alexander, 1993).

Male survivors are often plagued by shame, silence, guilt, and confusion that can contribute to underreporting the abuse and more notably hesitancy in seeking counselling (Bagley et al., 1994). Several researchers have documented that males in general are less likely to seek psychotherapy than women (Gold et al., 1999; Harrison & Morris, 2001; Lambert, 2004; Levant, 1990; Lisak, 2001). Furthermore, male survivors in particular often experience socialization patterns and pressures that may prevent them from seeing psychotherapy as a viable option (Harrison & Morris, 2001). It has been documented that

male survivors who do seek counselling often do so for other reasons either than the sexual abuse itself (Gill & Tutty, 1999). Ray (2001) found that only 1 of 25 male survivors sought counselling for sexual abuse. Instead, male survivors often seek counselling for a variety of other presenting issues such as relationship difficulties (Gill & Tutty, 1999).

Considering that helping professionals will likely encounter clients with a history of CSA (Paivio & Nieuwenhuis, 2001), it is important to explore the male survivor's experiences of therapy. It is vital to cultivate an understanding of what this particular population perceives to be helpful and unhelpful in counselling. There is a scarcity of research investigating male survivors' perspective of their counselling experience. Some insight into what survivors find helpful and unhelpful in counselling has been gained through research with female survivors (Armsworth, 1989 Carver et al., 1989; Wheeler et al., 1992). Armsworth (1989) suggested that helpful aspects in therapy include validation, advocacy, empathic understanding, and absence of contempt or punishment. A study investigating female survivors' perceptions of helpful aspects associated with group therapy found that having the ability to share with others, feeling understood, and learning that they were not alone were regarded as beneficial (Carver et al., 1989). Although these studies provide valuable information on the helpful factors in both group and individual therapy, the generalizibity of these results to the male survivor population is limited.

A study conducted by Dale, Allen & Measor (1998) examined clients' and counsellors' perceptions of helpful and unhelpful factors in counselling adult survivors of childhood abuse. Findings revealed that while there are several similarities between what

abused clients and the general client population perceive to be helpful and unhelpful in counselling, particular challenges also existed. These potential difficulties included significant difficulty in establishing effective working alliance, abuse-related cognitions and/or affect, inhibited communication in counselling, and a difficulty in expressing dissatisfaction with counselling. Although this study attempted to illustrate what survivors of childhood abuse found helpful and unhelpful in counselling, the male client perspective was under-represented. In addition, this study did not solely focus on CSA, but also included survivors of physical and emotional abuse. Research investigating male survivors' perspectives of helpful and unhelpful aspects of counselling is evidently scarce and thus warrants particular exploration.

It is vital to gain an understanding of how male survivors perceive the counselling experience, as evidence exists that therapists and clients often differ in their perspectives (Bachelor, 1991; Caskey, Barker, and Elliot, 1988; Elliot & James, 1989; Elliot & Shapiro, 1992; Heppner et al., 1992; Llewelyn, 1988). Although there is an extensive amount of literature examining the counselling process, this body of research has mostly focused on the therapists' account of what is helpful or unhelpful in therapy. While the therapists' perceptions of therapy are valuable, the client's experience and perspective can enrich what is known and understood about the counselling process (Heppner et al., 1992; Wilcox-Matthew, Al Ottens, & Minor, 1997). Hill and Alexander (1993) contend that in order to advance what is known about the therapeutic experience, process research is needed to determine the effectiveness of therapy. As researchers have identified the presence of differing perspectives between clients and therapists, additional empirical

studies are needed to gain a further understanding of the therapeutic process, as perceived by client populations, such as male survivors of CSA.

There are a number of factors that have fueled this study. The significant prevalence of male CSA and the associated after-effects have served as the initial impetus in studying this particular population. Additionally, studies have identified that many mental health professionals do not feel comfortable, competent or supported in their work with survivors of CSA (Day et al., 2003). Lab et al., (2000) investigated mental health professionals' attitudes and practices towards male survivors in particular. Results indicated that mental health professionals' knowledge of prevalence rates of male CSA was extremely varied. A significant portion of professionals in the study by Lab et al. (2000) reported not having any specific training in working with this population group and felt that additional training would be beneficial.

This present study attempts to increase our understanding of male survivors' perceptions of the therapeutic process. Since male survivors may have difficulty in seeking therapy (Harrison & Morris, 2001), it is important to explore the motivating factors for those who do attend counselling. Furthermore, this study explores the helpful and unhelpful aspects of counselling from the survivors' perspective to develop conceptual knowledge of these processes.

Chapter 3: Methodology

Background

Concept mapping is a methodological approach that attempts to capture and depict the underlying structures of a phenomenon as experienced by participants (Kunkel & Newsom, 1996). Fundamentally, concept mapping is rooted in the fields of education and cognitive psychology and attempts to "construct a bounded graphic representation that corresponds to a perceived reality" (Wandersee, 1990, p. 923). Concept mapping is a participant-oriented process, designed to gain an understanding of participants' experiences and perceptions (Paulson & Worth, 2002). The use of concept mapping is advantageous as a method of obtaining a relatively unconstrained description of a phenomenon as experienced by a particular population (Daughtry & Kunkel, 1993).

Concept mapping was initially employed in the areas of program planning and evaluation (Trochim, 1989); however, recently it has been applied in other spheres of research. This methodological approach has been utilized in the study of clients' experiences of depression, mental health services, suicide, counselling process, and employment programs (Daugherty & Kunkel, 1993; Kunkel & Newsom, 1996; Paulson & Worth, 2002; Paulson, Truscott, & Stuart, 1999; Trochim, Cook, & Setze, 1994).

Theoretical Constructs

Concept mapping entails three basic processes: (1) generation of ideas, thoughts, or experiences by participants regarding a specific question; (2) grouping together common interrelationships between ideas or experiences through an unstructured card sort; and (3) statistical analysis of the card sort results utilizing multidimensional scaling and hierarchical cluster analysis (Trochim, 1989). In the first stage of the concept

mapping process, participants' perspectives are obtained by asking open-ended questions regarding the phenomenon of interest. Questions are intended to be sufficiently focused to tap into the participants' experience or perspective, yet relatively vague so as to avoid any constraint in responses. The clarity of the research question is necessary to prevent participant confusion (Trochim, 1989). Participants' responses to the interview questions are collected, combined, reviewed, and distilled into phrases or statements. Jackson and Trochim (2002) identify two options for the review of participant-generated responses: (1) by two or more researchers together; or (2) by a group of participants who work together to appraise the responses. In reviewing participant responses, statements which capture the essence of their experiences and perceptions are retained. It is important to maintain as much as possible participants' language in order to encapsulate the contextual meaning of the statements (Jackson & Trochim, 2002).

The second phase of the concept mapping procedure involves an unstructured sort of the previously generated statements. For the sorting task, a second group of participants sort or group together conceptually similar ideas, thoughts, or experiences. The participants involved in the sorting phase may, or may not be, the same individuals who participated in the initial generation of the statements.

In the third stage, sorted data is analyzed using multidimensional scaling (MDS) and hierarchical cluster analysis. These methods of analysis identify the common categories evident in the item groupings determined by the individual sorters (Miller, Wiley & Wolfe, 1986). There are a number of multivariate statistical techniques available which can be used to cluster data into groups, including factor analysis, multidimensional scaling, cluster analysis, and latent partition analysis. In particular, factor analysis is a

widely used method used to identify underlying structure in a multivariate data set. While MDS is capable of analyzing ordinal data, factor analysis has been limited to the analysis of correlation coefficients (Davison, Richards, &Rounds, 1986). Furthermore, factor analysis has a restricted applicability and a comparatively complex interpretation process (Davison et al., 1986). Utilizing multi-dimensional scaling paired with cluster analysis is appropriate in obtaining an understanding of the participants' perception regarding the domain of interest (Kruskal & Wish, 1978; Miller, Wiley & Wolfe, 1986; Trochim, 1989).

Multidimensional scaling is a quantitative statistical approach designed to uncover the "hidden structure of data" (Kruskal & Wish, 1978). Essentially, MDS facilitates the examination of the relationship among a set of concepts as identified and perceived by participants (Davison et al., 1986; Buser, 1989). The application of the statistical procedure of MDS is used as a means of understanding the participants' perceptual world (Buser, 1989). Additionally, MDS has been identified as being especially suitable for spatially representing unknown relationships among variables (Fitzgerald & Hubert, 1987; Kruskal & Wish, 1978).

According to Davison et al., (1986), MDS employs an analogy between the concept of dissimilarity and the geometric concept of distance. In MDS, each of the statements provided by the participants is represented as a point on a concept map. MDS facilitates the arrangement of the statements (i.e., points) along orthogonal axes (Kruskal & Wish, 1978). The distance between any two points on the map reflects the frequency in which statements were sorted together by the participants (Buser, 1989).

As MDS does not categorize items into groups it is often used in combination with other statistical clustering approaches (Miller et al., 1986, Trochim, 1989). Hierarchical cluster analysis analyzes data from a proximity matrix to yield a representation of stimulus structure, but unlike MDS, which represented the underlying structure in terms of quantitative dimensions, the results are represented in term of qualitative categories (Davison, et al., 1986). As both cluster analysis and MDS reflect conceptual structures differently, they are often used together and viewed as complementary methods (Davison et. al., 1986; Kruskal & Wish, 1978; Miller, Wiley & Wolfe, 1986; Trochim, 1989). Essentially, hierarchical cluster analysis is a classification technique in which items are clustered into groups that are more alike than members of other groups within a complex data set (Borgan & Barnett, 1987). The natural groupings are not known a priori, thus by using a clustering algorithm the data is searched in order to partition the items into relatively distinct groups (Borgan & Barnett, 1987).

Following the analysis of the sorted data, each group of statements is visually inspected and assigned a label describing the thematic content of that particular group (Trochim, 1989). Once themes have been identified, a concept map can be constructed. The final result is a simplified and concise visual representation of the participants' conceptual process (Trochim, 1989).

Participants

A total of 25 participants took part in the study. An initial group of 20 adult male survivors participated in the statement generation phase. Fifteen of these 20 initial participants also performed the card sort. An additional 5 male survivors were recruited to take part in the sorting phase. Recruitment for both stages of the study was done

through newspaper and television advertisements. Additionally, pamphlets indicating the purpose of the study were distributed to a number of community and counselling agencies in Edmonton and surrounding communities (see Appendix B). A total of 19 participants came from Edmonton and 6 from Calgary, Alberta. Participants interested in taking part in the study contacted the researcher directly via telephone and/or email. Potential participants were screened on the basis of the following inclusion criteria: (1) adult males over the age of 18; (2) had at least one memory of CSA; (3) had attended at least one session of individual counselling. An additional criteria for the statement generation phase included that participants were not involved in individual counselling, as this could have impeded their ability to freely share their perceptions of the therapeutic process. Three participants in the sorting phase were in ongoing counselling; however, this was not a concern, as they were not responding to interview questions, but were sorting previously gathered statements. Participants reported dealing with a number of issues in counselling including substance abuse, low self-esteem, relationships difficulties, anger, depression, anxiety, family conflicts, grief and loss, sexual additions, feelings of guilt, eating disorders, suicide, and sexual abuse. Demographic information was collected from participants in the statement generation and sorting phases of the study (see Appendix D). Data related to background, counselling, and CSA was compiled and included the following: participant age, level of education, marital status, ethnic background, number of counselling sessions, counselling service provider, gender of abuser(s), relationship to the abuser, and whether participants experienced single or multiple incidents of CSA (see Table 1 and 2).

Table 1

Demographic Information of Participants in Statement Generation Phase

Description		n
Age	25-35	7
	36-44	4
	45-54	6
	55-64	3
Education	Grade school	3
	High school	1
	Post-Secondary	16
Marital Status	Married	5
	Single	8
	Separated/divorced	7
Ethnic Background	Euro-Canadian	15
	Aboriginal	3
	Latino	1
	East-Indian	1
# of Sessions	1-10	9
	11-20	4
	21-30	1
	50+	6
Service Provider	Psychologist	19
	Psychiatrist	8
	Social Worker	6
	Family Doctor	2
	Minister/Elder	6
Gender of Abuser	Male	11
	Female	3
	Both	6
Relationship	Family friend/Acquaintance	15
	Relative	4
	Guardian/Parent	7
	Babysitter	2
	Stranger	0
Incidents of Abuse	Multiple	20
	Single	3

Note. Demographic information collected from participants (N =20) in statement generation phase.

Table 2

Demographic Information of Participants in Statement Sorting Phase

Description		n
Age	25-35	8
	36-44	5
	45-54	5
	55-64	2
Education	Grade school	1
	High school	4
	Post-Secondary	15
Marital Status	Married	7
	Single	6
	Separated/divorced	7
Ethnic Background	Euro-Canadian	16
	Aboriginal	2
	Latino	1
	East-Indian	1
# of Sessions	1-10	8
	11-20	6
	21-30	1
	50+	5
Service Provider	Psychologist	18
	Psychiatrist	7
	Social Worker	10
	Family Doctor	6
	Minister/Elder	7
Gender of Abuser	Male	11
	Female	3
	Both	6
Relationship	Family friend/Acquaintance	12
	Relative	4
	Guardian/Parent	6
	Babysitter	3
	Stranger	2
Incidents of Abuse	Multiple	17
	Single	3

Note. Demographic information collected from participants (N =20) in the sorting phase.

Procedure

In accordance to the elemental components of the concept mapping approach, this study was procedurally divided into a statement generation stage followed by a statement sorting phase. For the initial data-gathering stage, participants interested in taking part in the study verbally provided their free and informed consent. In compliance with the University of Alberta Faculty of Education and Extension Research Ethics Board (see Appendix A), all participants were verbally made aware of the purpose of the research and their rights to confidentiality, anonymity, and withdrawal from the study (see Appendix C). Participants were given the option of sharing their counselling experiences via the telephone, email, mail, and in person. All participants were asked to respond to three open-ended questions: (1) "What motivated you to seek counselling?"; (2) "What aspects of counselling made a difference in dealing with your childhood sexual abuse"; and (3) "What would you change about your counselling experience?" (see Appendix E). In addition to the 3 interview questions, the researcher also prompted participants to elaborate on responses (i.e., "can you tell me more about that", "can you elaborate on that").

A total of 15 interviews were done via telephone, 3 in person, and 2 via email. Interviews conducted over the phone and in person took approximately 1 hour to complete. In-person interviews were conducted at the Faculty of Education Clinic Services, University of Alberta. Responses to the interview questions were manually recorded verbatim at the time of the interview. Once responses were gathered from participants, statements for each question were compiled. All responses provided by the participants were refined to obtain a set of statements that captured the fundamental

qualities of the participants' experiences in relation to the three questions. Seventy statements that reflected the participants' language were initially identified for the first question (i.e., "What motivated you to seek counselling"). Fifty nine statements were retained for the second question (i.e., "What aspects of counselling made a difference in dealing with your childhood sexual abuse?). Sixty two statements were related to the third question (i.e., "What would you change about your counselling experience?"). Employing the recommended procedure identified by Jackson & Trochim (2002), two researchers were involved in the review of the initial participant-generated statements. Both the primary researcher and study supervisor evaluated the three set of statements to identify overlap and redundancy. This resulted in a final list of 50 qualitative descriptive statements for question one; 49 for question two; and, 41 for question three.

The second stage of data collection consisted of having a second group of 20 participants sort the statements corresponding to the three separate questions. Fifteen participants who were involved in the first phase of the study agreed to complete the sorting task. Three of the initial 20 participants in the statement generation phase declined to participant in the sorting stage and 2 participants were unable to be contacted. For the sorting phase, an additional 5 participants were recruited. Participants were notified of the overall purpose and objectives of the study, as well as their rights to withdrawal, confidentiality, and anonymity. All participants provided their written consent to participant in the second phase of the study (see Appendix F). Both verbal and written instructions were provided for the sorting of the statements (see Appendix G). Participants were asked to read through the statements and sort them into groups in a way that made sense to them. There were no restrictions placed on either the size or number of

sorted groups. If participants felt that a statement was unrelated to the others, they were instructed to place it in its own pile. Given the sensitivity of the general topic of study, participants in both phases of the study were provided with a list of counselling referrals in the case that they felt any distress resulting from reflecting on issues related to their past abuse (see Appendix H).

A rating procedure designed to identify the relative importance of each statement for participants was not incorporated in this study. Although the rating component is commonly utilized with concept mapping, the large number of statements in the sorting phase would have likely resulted in participant fatigue.

Data Analysis

In the analysis phase of the concept mapping process, individual similarity matrices were computed for the sorted items. Data derived from the male survivors in the present study were analyzed using a computer program published by Concepts Systems Incorporated (Trochim, 1993). The MDS analysis approach was first applied to the card-sort data in order to suggest the organizational principal inherent in the participants sorting. A two-dimensional solution was utilized, as Kruskal & Wish (1978) point out:

> Since it is generally easier to work with two-dimensional configurations than with those involving more dimensions, ease of use considerations are also important for decisions about dimensionality. For example, when an MDS configuration is desired primarily as the foundation on which to display clustering results, then a two-dimensional configuration is far more useful than one involving three or more dimensions (p. 58).

Each statement resulting from the participants' responses is represented as a point on a concept map. Specifically, points that are closer together on the map represent statements that were frequently sorted together. Points that are farther apart indicate statements that were less frequently sorted together by the participants. The MDS

procedure generates a stress value for the two-dimensional solution, which illustrates the "goodness of fit" for the map to the original dissimilarity matrix that served as input. Essentially, the stress value is a numeric value representing the stability of the MDS solution and ranges from zero (perfectly stable) to one (perfectly unstable) (Kruskal & Wish, 1978). A lower stress value implies a better fit as opposed to a higher stress value (Kruskal & Wish, 1978).

In addition to the stress value, bridging indices are also generated as a result of the MDS analysis. Bridging values can range from 0 to 1 and demonstrate how frequently statements were sorted together (Paulson & Worth, 2002). Lower bridging values are indicative of statements frequently sorted together. Essentially, the lower the bridging index, the more likely that the statement was primarily sorted with statements which are close to it on the map (Trochim, 1993).

The second analysis approach applied to the sorted data involved a hierarchical cluster analysis procedure designed to identify conceptually similar themes. Hierarchical cluster analysis is based on Ward's (1963) algorithm, to sort items into internally consistent clusters with the cluster solution being superimposed on the MDS point plot. The hierarchical cluster analysis method searches the proximity matrix and groups statements based on the distance value between them. The method continues to delineate groups in away that minimizes within-in group variance (Ward, 1963).

Choosing the number of clusters for interpretation consisted of examining an initial cluster solution that placed approximately one-fifth of the statements into each cluster (Trochim et al., 1994). Successively lower and higher cluster solutions were produced and examined. The number of clusters chosen was based on the objective of

yielding sensible general concepts wherein the items within each cluster seemed to be conceptually similar (Trochim, 1993). The final number and names of the clusters were assigned by the primary researcher and supervisor. In determining cluster names, primary consideration was given to the bridging indices, indicating the relative distance of each item to other items on the map. Specifically, statements were reviewed starting from the lowest bridging value to the highest bridging value in each cluster. This was followed by creating a phrase or word that best described the statements as a set (Trochim, 1993).

Methodological Strengths

There are a number of advantages associated with the concept mapping approach. Fundamentally, concept mapping allows for the investigation and study of constructs as experienced by participants, rather than defined by the researcher (Daughtry & Kunkel, 1991) This method facilitates the active participation of participants in item generation and data gathering (Trochim, 1989). Given that participants are heavily involved in the sorting process, this helps to avoid some of the issues associated with researcher-generated coding schemes, thus adding to the validity to the sorted data. Consequently, the concept mapping method reduces the potential for bias and subjectivity often present in having the researcher sort qualitative data. Results generate a conceptually clear pictorial representation of all the salient ideas, as well as their interrelationship (Trochim, 1989).

Methodological Limitations

Despite the apparent strengths of the concept mapping approach, there is also a notable methodological limitation. One potential limitation appears to be inherent in the first step of the concept mapping process (i.e., generation of statements). Once the

statements are collected from the participants, it is imperative to examine, reconstruct, and "unitize" the statements into one-concept phrases (Jackson & Trochim, 2002). As such, it is possible that by having researchers employed in the process of statement unitization the intent of the statements can be altered (Jackson & Trochim, 2002). Furthermore, the way in which units are created may limit the participants' contextual information included in the statements. Given these drawbacks, it is extremely important for participants to be involved in the sorting process to ensure accuracy of the data. Despite these potential limitations, it is often not feasible for participants to be involved in the statement clarification process and instead their participation is preferred in the sorting of the statements as means to sustain statement validity (Jackson & Trochim, 2002).

Chapter 4: Results

The findings of this study serve to provide insight and understanding of the counselling process experienced by male survivors of CSA. The data gathered in the statement generation phase helps to identify what motivates male survivors to seek counselling, as well as what they find helpful and unhelpful in therapy. Thematic clusters indicating several areas of the counselling process describe some of the underlying structures of male survivors' experiences of therapy from their perspective. Specific statistical applications were applied to the data in order to render a graphic and thematic representation of participants' responses and reflections.

Multidimensional scaling arranged points which represent the statements along orthogonal axes such that the distance between any two points indicates the frequency with which the items were sorted together (Kruskal & Wish, 1978). The MDS analysis method generated a stress value for each of the three maps. The stress value is the numerical representation of the "goodness of fit" and the stability of the MDS solution (Kruskal & Wish, 1978; Paulson & Worth, 2002). Kruskal & Wish (1978) identify that there is no particular numerical value associated with an optimal stress value. Instead, the interpretation of stress values depends on the number of statements and dimensionality (Kruskal & Wish, 1978). Stable stress levels in the research literature have ranged from 0.25 to 0.31 (Daughtry & Kunkel, 1993; Kunkel & Newsom, 1996; Paulson et al., 1999; Paulson & Worth, 2002; Trochim & Cook, 1993; Trochim et al., 1994). Additionally, bridging indices were produced for each of statement in the three maps. The bridging index reflects how frequently statements are sorted together (Trochim, 1993). A low

index is indicative that the statement was closely sorted with other statements on the map (Trochim, 1989).

Hierarchical cluster analysis of the MDS similarity matrix was then employed to group sorted items in internally consistent clusters. Given that the cluster solution was established on estimated distances between items for the MDS two-dimensional solution, the cluster solution was utilized as a secondary guide to interpreting the maps. The solution generated by the MDS procedure (i.e., relative distance of items on map) was given primary consideration (Paulson & Worth, 2002).

Motivation to Seek Counselling

In response to the first research question, "What motivated you to seek counselling" a total of 50 statements were sorted. The MDS procedure resulted in final stress value of 0.21 for a two-dimensional solution, which is considered to be stable. The concept map indicates the 50 aspects associated with the participants' perceptions of what motivated them to seek counselling (see Figure 1). Each of the 50 statements is represented by a point on the map. The relative position of the points was derived from the MDS solution. The cluster boundaries around groups of points illustrate statements that were more frequently sorted together. A statement key, statements within each cluster and bridging values are presented in Table 3.

Analysis of the first map in Figure 1 resulted in the identification and conceptualization of four major thematic clusters. In terms to the motivating factors associated with male survivors seeking counselling, it appears that participants were compelled to attend counselling for issues related to: (1) self-exploration and self-

understanding; (2) negative sense of self; (3) emotional distress; and (4) relationship difficulties.

Further examination of map 1 (see Figure 1) reveals that participants' motivations in seeking counselling appear to be move along a continuum from internal processes starting on the right-hand side of the map to interpersonal-relational aspects on the left hand side. A bottom-to-top examination of the map suggest a continuum of processes that clients perceived to be difficult or negative on the bottom half of the map to issues related to self-betterment in the top half.

A closer look at the map (see Figure 1) reveals that starting at the bottom right-hand portion of the map indicates aspects of emotional distress and a negative sense of self. The proximity of Clusters 2 (negative sense of self) and 3 (emotional distress) suggests that participants perceived these two aspects as conceptually similar in relation to motivations in seeking counselling. Of the four thematic clusters, results indicate that Cluster 2 had the lowest bridging value (0.14). The low bridging value suggests that participants consistently sorted the items in cluster 2 together. Specifically, Cluster 2 indicated the participants' sense of disconnectedness (e.g., "I felt disconnected from myself"), hopelessness (e.g., "I felt hopelessness"), self-hatred (e.g., "I hated who I was") and self-rejection (e.g., "I was struggling with feelings of self-rejection). On the bottom right-hand side of the map, it appears that participants sorted together items associated with emotional distress (e.g., "I felt emotionally numb"). In particular, Cluster 3 illustrated participants' emotional experiences of anxiety (e.g., I was experiencing intense feelings of anxiety"), depression (e.g., "I was feeling depressed"), guilt (e.g., "I was feeling extreme guilt") and suicidal tendencies (e.g., "I attempted to commit suicide") as

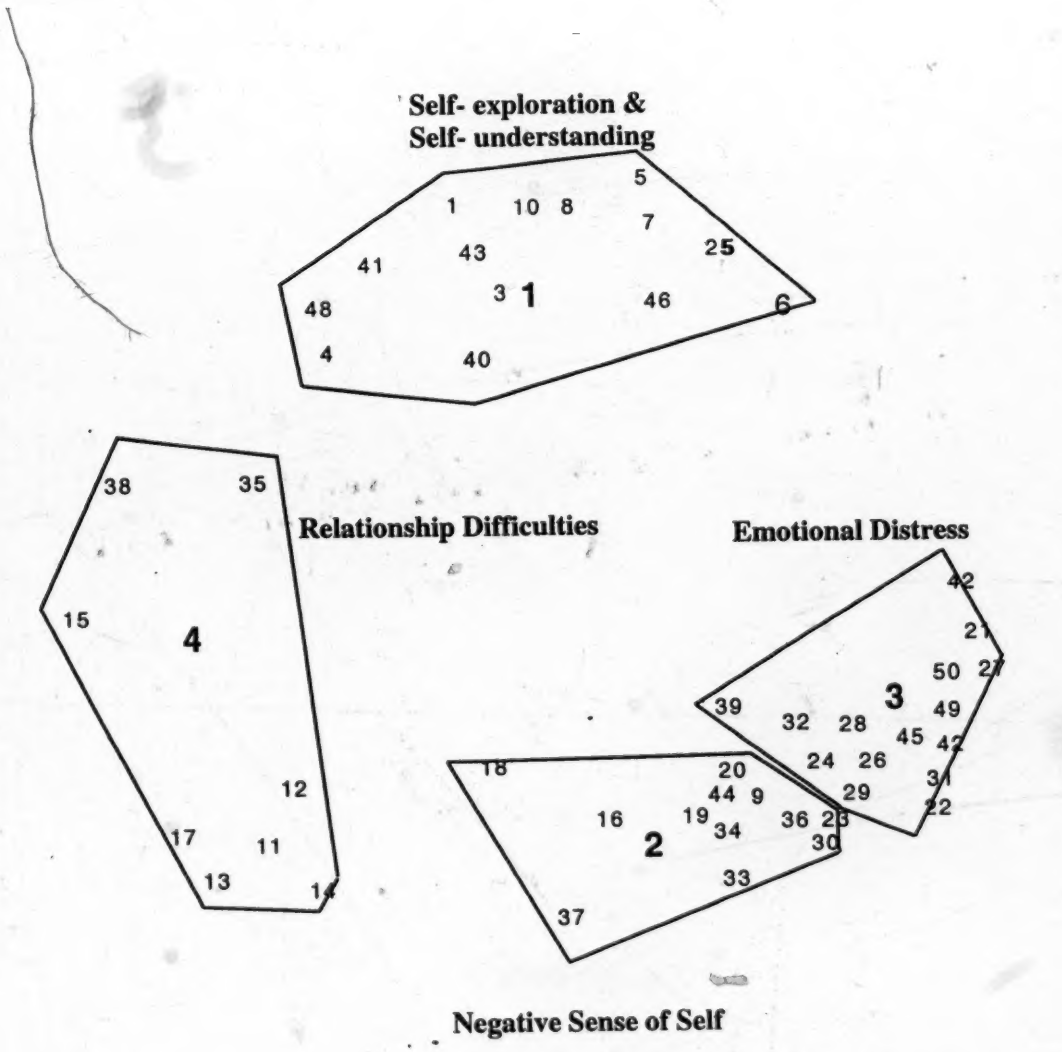
motivating aspects in seeking counselling. The low bridging index of 0.18 for Cluster 3 demonstrates that participants frequently sorted these items together.

Moving along the continuum from the right hand-side to the left-side indicates the presence of a thematic cluster related to the aspects of self-exploration. Specifically, Cluster 1 (self-exploration and self-understanding) reveals that participants frequently sorted together (i.e., bridging value of 0. 30) items associated with self-understanding (e.g., "I wanted to understand why I had an addiction"; "I wanted to learn about myself") self-identity (e.g., "I wanted to explore issues related to my sexual identity") and issues related to sexual abuse (e.g., "I wanted to stop the cycle of abuse"; I wanted to explore the positive aspects of my experience of sexual abuse"). It appears that in addition to a negative sense of self and emotional distress, participants identified those issues related to self-exploration and understanding as motivating factors in seeking counselling.

In examining the left hand side of the map, it appears that Cluster 4 (relationship difficulties) was identified as another aspect associated with engaging in counselling. Cluster 4 in particular had the highest bridging value of 0.74, suggesting that items could have been potentially placed in any other groups. Essentially, participants were often unsure where to sort the statements in Cluster 4 within the overall counselling process. Despite the high bridging average, many of the items in the cluster appeared to be related to relationship issues (e.g., "I was having a difficult time with my intimate relationships"; "I was feeling dissatisfied with my relationships").

Figure 1

Concept Map of What Motivated Male Survivors to Seek Counselling



Note. Results derived from qualitative analysis of participant responses to "What motivated you to seek counselling?" Findings based on multidimensional and cluster analysis of 50 statements sorted by 20 participants.

Table 3

Clusters and Items from Concept Map of What Motivated Male Survivors to Seek Counselling

Cluster/Item	Bridging Value
Cluster 1: Self-exploration and Self-understanding	0.30
8. I wanted to better myself	0.13
5. I wanted to learn about myself	0.14
10. I wanted to understand myself	0.15
1. I wanted to understand why I had an addiction	0.18
2. I wanted to explore issues related to my sexual identity	0.19
47. I wanted to explore the positive aspects of the abuse	0.21
7. I wanted to see if I could change	0.21
43. I wanted to see if there was a link between the decisions I made and the sexual abuse	0.26
3. I wanted to understand why I had frequent sexual fantasies	0.28
41. I wanted to stop the cycle of abuse	0.29
46. I wanted to gain self-confidence	0.34
25. I wanted to understand the emotions I was feeling	0.37
40. I needed to address my issues of sexual abuse	0.41
6. I was concerned that my life wasn't going where I wanted it to	0.52
48. I realized that the sexual abuse I experienced was wrong	0.54
4. I was searching for psychological guidance	0.60
Cluster 2: Negative Sense of Self	0.14
30. I felt disconnected from myself	0.00
36. I felt hopelessness	0.00
9. I hated who I was	0.03
23. I was feeling emotionally overwhelmed	0.05
44. I didn't respect myself	0.06
20. I felt lost	0.07

Table 3

(continued)

Cluster/Item	Bridging Value
34. I was struggling with feelings of self-rejection	0.10
33. I was feeling insecure about myself	0.11
19. I was experiencing intense anger	0.17
16. I felt emotionally disconnected from others	0.26
37. I was extremely perfectionistic	0.42
18. I was isolating myself from others	0.43
Cluster 3: Emotional Distress	0.18
26. I felt emotionally numb	0.05
32. I was having panic attacks	0.07
24. I was experiencing intense feelings of anxiety	0.08
28. I was feeling depressed	0.08
29. I was feeling extreme guilt	0.09
49. I was in a lot of emotional pain	0.11
39. I attempted to commit suicide	0.14
22. I was emotionally out of control	0.14
31. I was dealing with intense unresolved grief	0.15
45. I didn't take care of myself	0.16
50. I felt I was desperate	0.26
27. I felt like there was no purpose in my life	0.37
21. I experienced flashbacks of the abuse	0.40
42. I was having large gaps in my memory	0.43
Cluster 4: Relationship Difficulties	0.74
14. I felt that I was not good enough in my relationships	0.56
11. I was having a difficult time with my intimate relationships	0.62
12. I was emotionally hurting others	0.66
13. I lost an important relationship in my life	0.70
35. I was scared that I was going to turn into my abuser	0.72

Table 3

(continued)

Cluster/ Item	Bridging Value
17. I was feeling dissatisfied with my relationships	0.73
15. I went to counselling to deal with family issues	0.96
38. I was mandated to attend counselling	1.00

Note. Participants (N=20) sorted statements (N=50) related to male survivors' motivation in seeking counselling into similar groups.

Helpful Counselling Experiences

In terms of helpful experiences in individual counselling, participants responded to the second question, "What aspects of counselling made a difference in dealing with your childhood sexual abuse?" Participant responses generated a total of 49 statements that were then sorted. For this second set of statements, the MDS procedure resulted in final stress value of 0.24 for a two-dimensional solution, and is regarded as a stable solution. The concept map indicates 49 aspects inherent in what participants perceived to be helpful in counselling (see Figure 2). A total of five elements of counselling were identified as being helpful: (1) client growth and awareness; (2) therapist interventions; (3) therapist interpersonal qualities; (4) positive therapeutic relationship; and (5) emotional expression. A statement key, statements within each cluster and bridging values are presented in Table 4.

Analysis of the map (see Figure 2) on helpful counselling experiences depicts a continuum moving from therapeutic elements on the right-hand side to affective expression and personal growth aspects on the left-hand side. A bottom to top assessment of the map reveals a concentration of the qualities facilitated by the therapist and process related to therapy in the bottom right hand side to self-reflective and expressive aspects on the upper left-hand side.

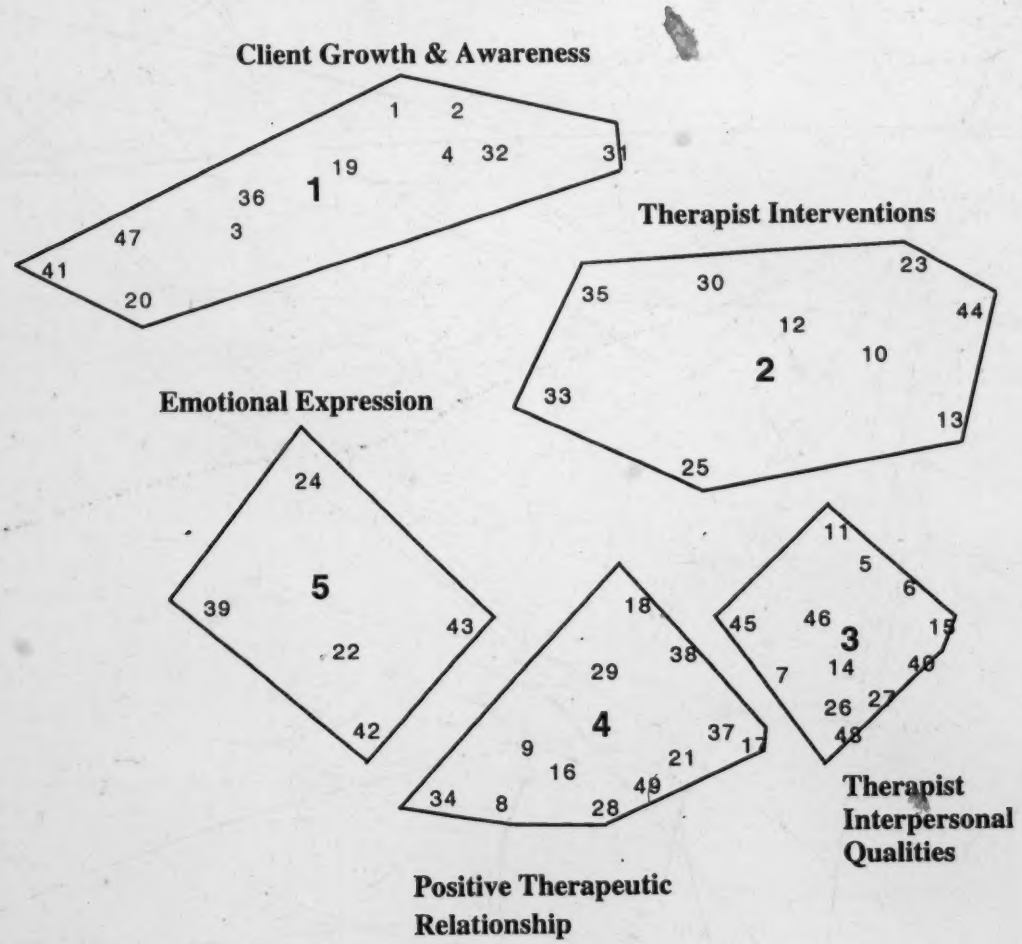
Further examination of the map illustrates that along the right-hand side, Clusters 2 (therapist interventions), 3 (therapist interpersonal qualities), and 4 (positive therapeutic relationship) are indicative of helpful counselling processes. Specifically, participants' sorted together items connected with the therapists' interpersonal qualities (e.g., "My therapist was compassionate"), the positive therapeutic relationship (e.g., "My therapist

made me feel comfortable"; " My therapist believed my story"), and the interventions the therapist employed in counselling (e.g., "My therapist incorporated a spiritual component to therapy"). Cluster 3 had the lowest bridging value (0.10), suggesting that participants consistently sorted these items together in the same cluster. Additionally, Cluster 4 had a relatively low bridging value (0.14), demonstrating that participants frequently sorted items in this cluster together.

Inspecting the left-hand side of the map illustrates two thematic clusters involving client affective expression and growth processes. Specifically, Cluster 5 (emotional expression) reveals that participants consistently sorted together (i.e., bridging value of 0. 52) items associated with the expression of emotion with the therapist (e.g., "It was helpful that my therapist and I were able to laugh together"), and the experience of emotion within session (e.g., "I was able to experience my emotions in a safe place"). Cluster 1 exemplifies the helpfulness of client growth and awareness. Although this particular cluster has a high bridging value (0.71) indicating that participants were unsure of how this cluster fit in the overall scheme of the counselling process, items appear to be related to helpful internal client processes (e.g., "Counselling helped me develop trust in others"; "Counselling helped me identify my emotions").

Figure 2

Concept Map of Male Survivors' Helpful Experiences in Counselling



Note. Results derived from qualitative analysis of participant responses to "What aspects of counseling made a positive difference in dealing with your childhood sexual abuse? Findings based on multidimensional and cluster analysis of 49 statements sorted by 20 participants.

Table 4

Clusters and Items from Concept Map of Male Survivors' Helpful Experiences in Counselling

Cluster/Item	Bridging Value
Cluster 1: Client Growth and Awareness	0.71
32. Counselling helped me to develop trust in others	0.56
4. Counselling helped me identify my emotions	0.58
2. Therapy helped me deal with my anxiety	0.60
31. Therapy helped me establish relationship boundaries	0.62
19. Counselling helped me keep my relationships alive	0.64
1. I gained an understanding of my triggers	0.65
36. Counselling helped learn how to communicate my feelings	0.68
3. Therapy enhanced my self-awareness	0.72
20. Counselling helped me understand how I had been relating within my family	0.88
47. I learned how I viewed myself	0.89
41. I realized that I am a stronger person because of the abuse	1.00
Cluster 2: Therapist Interventions	0.41
25. My therapist incorporated a spiritual component to therapy	0.18
33. My therapist helped me realize I was not alone	0.29
12. My therapist helped me shift my perspective from the negative to the positive	0.38
35. My therapist helped me understand that the abuse wasn't my fault	0.39
10. My therapist challenged my thoughts	0.39
30. My therapist helped me see the options I had in my life	0.43
13. My therapist explained the purpose of counselling	0.46
23. My therapist provided me with information about sexual abuse	0.58
44. My therapist referred me to the literature on sexual abuse	0.61

Table 4

(continued)

Cluster/Item	Bridging Value
Cluster 3: Therapist Interpersonal Qualities	0.10
7. My therapist was compassionate	0.00
14. My therapist didn't try to give me a "label" or diagnosis	0.02
45. My therapist reassured me that he/she was willing to help me	0.04
46. My therapist respected my world-view	0.06
27. My therapist was gentle in his/her approach	0.07
26. My therapist was patient	0.08
48. My therapist was empathetic	0.10
40. My therapist didn't force me to disclose the details of the abuse	0.13
11. My therapist was consistent in his/her approach	0.16
5. My therapist listened to my story of sexual abuse	0.18
15. My therapist had experience in working with survivors	0.20
6. My therapist allowed me to talk about my experiences	0.20
Cluster 4: Positive Therapeutic Relationship	0.14
37. My therapist believed my story	0.00
21. My therapist made me feel comfortable	0.02
38. My therapist didn't question the validity of what I was experiencing	0.02
17. My therapist didn't judge me	0.03
29. My therapist respected my culture	0.08
18. My therapist was aware of my needs	0.09
49. I felt that my therapist was there for me	0.12
9. I felt I could be open with my therapist	0.16
16. I felt understood by my therapist	0.16
28. I felt I could trust my therapist	0.17
8. I felt supported	0.28
34. The gender of my therapist affected my comfort level	0.51

Table 4

(continued)

Cluster/Item	Bridging Value
Cluster 5: Emotional Expression	0.52
43. It was helpful that my therapist and I were able to laugh together	0.29
22. I was able to experience my emotions in a safe place	0.44
42. I felt emotionally connected to my therapist	0.47
24. I was able to express my emotions in a variety of ways (e.g., poetry)	0.60
39. Counselling was collaborative	0.81

Note. Participants (N=20) sorted statements (N=49) related to helpful counselling processes into similar groups.

Unhelpful Counselling Experiences

In response to the third question, "What would you change about your counselling experience", 41 participant responses were sorted. The final stress value is 0.33 for a two-dimensional solution and is considered to be a stable MDS solution (Kruskal & Wish, 1978). The concept map indicates the 41 aspects associated with the participants' perceptions of what they would change about their counselling experience (see Figure 3). Analysis of the third map reveals five major factors: (1) therapist receptiveness; (2) ineffective therapeutic intervention; (3) lack of therapeutic attunement; (4) insufficient therapeutic preparation; and (5) negative therapeutic relationship. A statement key, statements within each cluster and bridging values are presented in Table 5.

Careful analysis of the map (see Figure 3) depicting the unhelpful elements in counselling reveals a fairly clear continuum from top-to-bottom. Specifically, aspects associated with the therapeutic relationship and interpersonal client/therapist processes are concentrated in the top half of the map. Therapeutic approaches are primarily located on the bottom portion of the map. Conceptualizing the map in this manner creates two broad yet distinguishable categories, namely client/therapist interpersonal process and counselling interventions.

Further examination of the map starting at the top left-hand portion and moving along to the top right-hand portion suggests aspects related to interpersonal therapeutic themes. Cluster 5 indicates that participants sorted together items associated with the therapists' inability to meet client needs (e.g., "My therapist made recommendations for alternative treatments I wasn't ready for"), the therapists' inattention to the client (e.g., I didn't feel that my therapist was paying attention to me"; "I would have liked for my

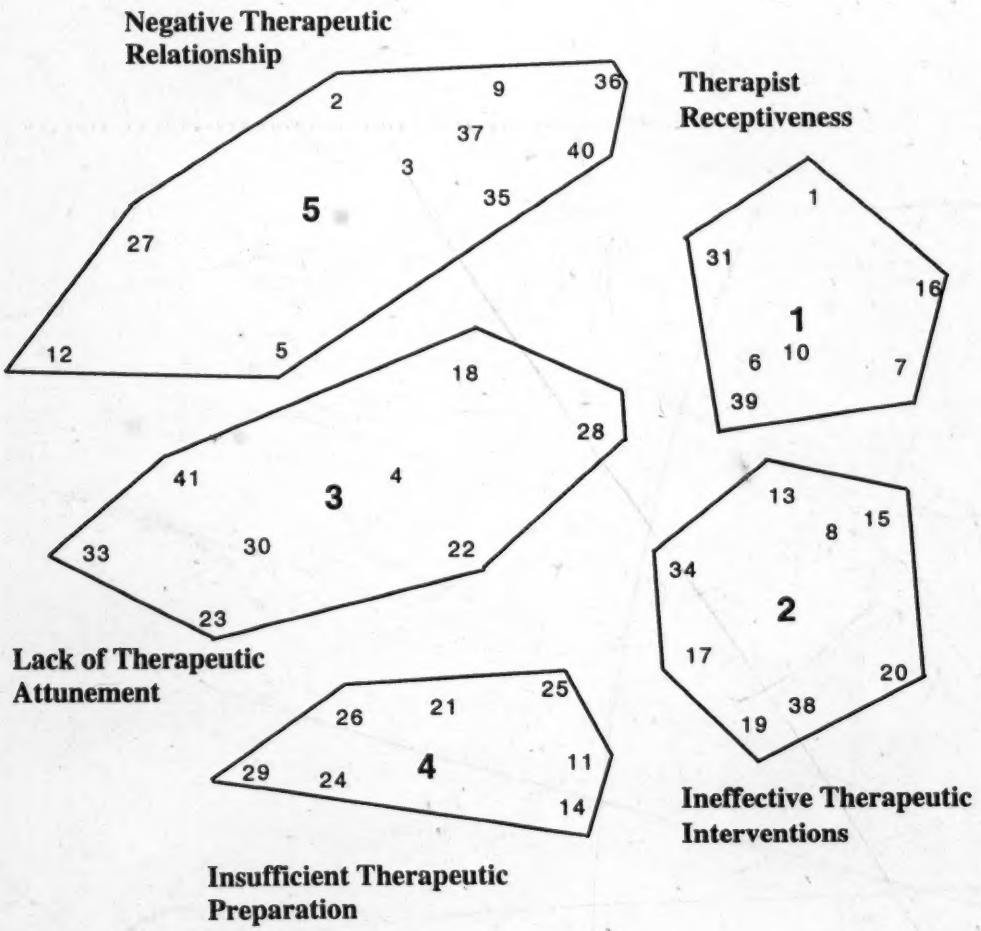
therapist to have listened to me"), and the therapists' inability to establish and maintain a trust within the therapeutic relationship (e.g., "I needed for my therapist to have upheld confidentiality"; "I felt that my therapist blamed me for the abuse"). It appears that participants sorted items in this cluster that were representative of the negative therapeutic relationship. Moving to the top right-hand portion of the map suggests conditions associated with the theme of therapist receptiveness. Specifically, participants frequently sorted together items connected to the therapist's lack of responding to pertinent client issues (e.g., "My therapist focused on issues that I didn't feel were helpful"), therapist' inability to deal with client's experiences (e.g., "My therapist seemed unable to deal with my intense emotions"), lack of therapists' empathetic responses (e.g., "My therapist needed to be less judgmental") and negative responses to the clients' disclosure of sexual abuse (e.g., "My therapist told me I should have stopped the abuse"). The bridging indices for the top potions of the map indicate fairly low values (i.e., Cluster 1 = 0.25; Cluster 5 = 0.46), indicating that these items were overall consistently sorted in these clusters.

Inspecting the lower half of the map suggests that themes consistent with therapeutic approaches and interventions were mainly located in this area. In particular, participants sorted together items related to the need for individualized therapy (e.g., "My therapist needed to tailor therapy to meet my particular needs"), therapeutic flexibility (e.g., "My therapist needed to be more flexible in his/her approach), and therapeutic pacing (e.g., "I would have liked my therapist to have ended therapy in a way that I didn't feel abandoned). Examining the lower right-hand side of the map suggests conditions associated with unhelpful therapeutic interventions. Here participants sorted together

items related to lack of a collaborative approach (e.g., "I would have liked my therapist to have asked me for my feedback in how the sessions were going") and specific therapist interventions (e.g., "My therapist needed to be in the "here and now" during therapy"; "I needed a more directive therapist"). At the lower left-hand segment of the map is the thematic cluster linked to client preparation (e.g., "My therapist needed to ensure that I had a support system before delving into the sexual abuse"), and therapeutic structure (e.g., "I wanted some education of the common experienced of male survivors"; I needed to be offered options").

Figure 3

Concept Map of Male Survivors' Unhelpful Counselling Experiences



Note. Results derived from qualitative analysis of participant responses to "What would you change about your counselling experience?" Findings based on multidimensional and cluster analysis of 41 statements sorted by 20 participants.

Table 5

Clusters and Items from Concept Map of Male Survivors' Unhelpful Experiences in Counselling

Cluster/Item	Bridging Value
Cluster 1: Therapist Receptiveness	0.25
39. My therapist focused on issues that I didn't feel were important	0.02
6. My therapist seemed unable to deal with the intensity of what I was experiencing	0.10
31. My therapist needed to be less judgmental	0.17
10. My therapist didn't focus on the abuse	0. 20
1. My therapist told me I should have stopped the abuse	0.37
7. My therapist said that he/she couldn't help me	0.41
16. My therapist needed to me more compassionate	0.51
Cluster 2: Ineffective Therapeutic Intervention	0.30
34. My therapist needed to have asked me for my feedback in how the sessions were going	0.09
17. My therapist needed to be in the "here and now" during therapy	0.19
13. I needed a more directive therapist	0.24
8. I didn't feel that I could trust my therapist	0.30
15. My therapist needed to be more supportive	0.33
19. My therapist needed to focus on my emotions	0.36
38. I would have liked my therapist to have asked more questions	0.39
20. My therapist needed to communicate encouragement	0.46
Cluster 3: Lack of Therapeutic Attunement	0.32
23. I needed for my therapist to have believed me when I disclosed the abuse	0.00
18. My therapist needed to tailor therapy to my particular needs	0.06
22. My therapist needed to be more flexible in his/her approach	0.07

Table 5

(continued)

Cluster and item	Bridging Value
4. I would have liked my therapist to have ended therapy in a way that I didn't feel abandoned	0.11
30. I would have liked my therapist to have understood me	0.35
41. I would have liked to have a choice of my therapist's gender	0.53
23. My therapist needed to address my extreme isolation	0.56
33. I would have liked my therapist to have offered more feedback	0.86
Cluster 4: Insufficient Therapeutic Preparation	0.49
25. My therapist needed to ensure that I had a support system before delving into the sexual abuse	0.28
21. I needed to be offered options	0.31
11. I wanted education of the common experiences of male survivors	0.35
26. I wanted my therapist to incorporate expressive forms of therapy	0.40
14. I wanted reassurance that I would survive this experience	0.58
24. I felt I needed more sessions	0.69
29. I needed my therapist to have been educated about sexual abuse	0.80
Cluster 5: Negative Therapeutic Relationship	0.46
35. My therapist made recommendations for alternative treatments I wasn't ready for	0.18
37. I needed for my therapist to have been less focused on medicating me	0.21
40. I felt that my therapist wanted to "fix" me	0.28
5. I didn't feel that my therapist was paying attention to me	0.29
36. I felt that my therapist blamed me for the abuse	0.38
3. I would have liked my therapist to have listened to me	0.39
32. I needed for my therapist to have upheld confidentiality	0.45
9. My therapist was also a survivor who had not dealt with past sexual abuse	0.49
2. I would have liked a therapist who wasn't focused on labeling me	0.60

Table 5

(continued)

Cluster and item	Bridging Value
27. I needed my therapist to have incorporated culturally sensitive methods of counselling	0.83
12. I would do more research into my therapist's credentials	1.00

Note. Participants (N=20) sorted statements (N=41) related to unhelpful counselling processes into similar groups.

Summary

The concept maps generated by the participants enhance our understanding of how male survivors perceive and experience the counselling process. Findings illustrate that male survivors do not tend to seek therapy to directly deal with their history of CSA. Rather, counselling seems to be sought for reasons that are likely connected to the abuse, such as a negative sense of self and difficulties in Emotional distress. Once engaged in therapy, participants identified the value of the therapeutic relationship, therapist interventions, emotional expression, as well as client growth and awareness. A lack of acceptance, compassion, pacing, and preparation was highlighted as unhelpful elements in counselling.

Chapter 5: Discussion

The intent of this study was to increase our understanding of male survivors' experiences in counselling. While several findings of this study confirm existing literature, results also indicate new themes which have not been previously identified by researchers. Participants' responses supported the already established conception that male survivors often tend to seek counselling for reasons that may not seem directly or explicitly related to their CSA. In particular, male survivors sought to deal with the many symptomatic consequences associated with their CSA. Although the importance of a supportive therapist and positive therapeutic climate has been well documented, the value of exploring internal strength, emotional processes, and self-conceptions was acknowledged as being especially helpful for this client population. The theme of client growth and awareness has been previously explored in other clinical populations (Elliot & James, 1989; Paulson et al., 1999; Wilcox-Matthew et al., 1997); however, male survivors perceived this as particularly connected to self-understanding and reflection. The lack of therapeutic preparation provided in therapy is a unique finding of this study that enhances what is known about unhelpful counselling processes experienced by male survivors. These preparatory elements included the need for participants to have a support system, reassurance, and education on issues related to CSA. Exploring male survivors' perspectives on their counselling experiences serves to enhance our appreciation of what can be important when working with this specific client group.

Motivation to Seek Counselling

As the understanding of what motivates male survivors to seek counselling is a relatively new and untapped area of research (Ray, 2001), one of the goals of this study

was to explore potential motivating factors experienced by male survivors seeking therapy. A total of 4 themes describing participants' reasons for engaging in counselling were generated. These thematic clusters consisted of (1) negative sense of self; (2) emotional distress; (3) relationship difficulties; and (4) self–exploration and self-understanding. The responses provided by participants support the existing literature associated with the long-term psychological effects of CSA (Abdulrehman & De Luca, 2001; Beitchman et al., 1992; Briere et al., 1988; Briere & Runtz, 1993; Cahill et al.,1991; Collings, 1995; Dimock, 1988; Draucker & Petrovic, 1996; Dhaliwal et al., 1996; Fater & Mullaney, 2000; Gill & Tutty, 1997; Gold et al., 1999; Hunter, 1991; King et al., 2002; Mullen et al., 1996; Myers, 1989; Nurcombe, 1999; Olsen, 1990; Pierce & Pierce, 1985; Ray, 2001; Urquiza & Capra, 1990). It appears that male survivors tend to seek counselling to deal with the symptomatic aftermath of their CSA.

Negative sense of self. The trauma of CSA is said to have a significant impact on a male survivor's feelings and self-perceptions (Gartner, 1999; Lisak, 2001). Male survivors are reported to have experienced a fundamental childhood betrayal that influences their overall self-conceptions (Dorais, 2002; Gartner, 1999; Gill & Tutty, 1997). The thematic cluster indicative of a negative sense of self clearly illustrates participants' experiences of self-hatred, self-rejection, hopelessness, insecurity, and disconnection from self and others. Not only were these experiences a reality for the participants in this study, but they also became motivating factors in seeking counselling.

The theme of negative sense of self identified by the participants has been well documented in the literature as being linked to the male socialization process. Many men feel a strong societal pressure to conform to specific gender role conceptions (Dorais,

2002; Draucker & Petrovic, 1996; Romano & DeLuca, 2001). Societal expectations endorse the idea that men are to be powerful, secure, and confident (Struve, 1990). The loss of control and the experience of helplessness as a result of CSA can lead to a male survivor's negative sense of self. A male survivor's struggle with self-hatred, self-rejection, helplessness, and disconnection is a result of a core violation of his internalized sense of masculinity (Lisak et al., 1996). Gartner (1999) contends that because of such internalized ideals of masculine identity and the inability to meet these ideals, male survivors can experience extremely negative self-perceptions and feelings. Participants' reflections of self-hatred and lack of self-respect has been previously identified as aspects of self-devaluation (Olsen, 1990). Male survivors' feelings of vulnerability, shame, and insecurity have a profound impact on the way in which they perceive themselves and can be a motivating factor in seeking therapy.

Emotional distress. At the core of the traumatic experience of CSA, are overwhelming feelings of fear, helplessness, vulnerability, and anxiety (Lisak, 2001). Childhood sexual trauma is said to overwhelm an individual's sense of emotional coping (Herman, 1997). Emotional distress was clearly indicated by participants as being the impetus in beginning therapy. Among these emotions were feelings of numbness, anxiety, depression, guilt, grief, and desperation. Additionally, participants were motivated to seek counselling due to experiencing flashbacks and suicidal feelings. Male survivors are often emotionally numb and withdrawn or filled with uncontrolled and frightening rage (Gartner, 1999; Gold et al., 1999; Lisak, 2001; Ray, 2001; Romano & De Luca, 2001).

In reacting to trauma, a male survivor is often threatened with emotional over-arousal and an intense array of emotions that may be difficult to regulate. Disrupted affective processes have been cited as one of the primary aftereffects of CSA (Paivio & Nieuwenhuis, 2001). Gartner (1999) states that during the time in which a boy is learning to experience and control his emotions, he is instead flooded with intense feelings which he is unable to regulate. This emotional deregulation resulting from the sexual abuse can lead to immediate and long-term numbness, rage, anxiety, depression, and guilt.

Relationship difficulties. A traumatic experience, such as CSA can call into question basic human relationships (Herman, 1997). The thematic cluster referring to relationship difficulties was acknowledged as a source of distress that perpetuated male survivors to attend counselling. This finding is consistent with other studies (Gill & Tutty, 1999; Gonsiorek, Bera, & LeTourneau, 1994; Ray, 2001) which reported that male survivors initially sought therapy to work on relational issues. Interpersonal difficulties have been established as a common experience among survivors of CSA (Briere & Runtz, 1993; Draucker & Petrovic, 1996; Fater &Mullaney, 2000; Gartner, 1999; King et al., 2002; Sanderson, 1995). Childhood sexual abuse breaches the safety inherent in the attachments of family, friendship, love, and community, compromising the survivor's self-perception and self-construction in relation to others (Abdulrehman & De Luca, 2001; Bolton et al., 1989; Fergusson & Mullen, 1999; Gartner, 1999; Sanderson, 1995).

Childhood sexual abuse can be conceptualized as a betrayal of the relationship with the abuser, which influences a male survivor's ability to establish and maintain positive and healthy interpersonal relations (Gartner, 1999). A lack of trust, hostility, and fear has been linked to some of the reasons why male survivors may have difficulties in

their interpersonal relationships (Ray, 2001). It is likely that the aspects which often accompany a primary relationship, such as intimacy, sexuality, and trust are particularly challenging and motivate male survivors to seek therapy.

Self-exploration and self-understanding. The desire to engage in self-exploration and self-understanding was also identified by participants as the basis for pursuing counselling. A sense of readiness and preparedness to explore oneself and engage in change has been associated with the psychotherapeutic process. Clarkin and Levy (2004) indicate that a client's motivation, desire for therapy, and expectation of change is greatly related to a client's incentive to pursue therapy. The thematic elements in this particular cluster are congruent with the preparation stage of change identified by Prochaska and Norcross (2003). A client's readiness or preparation to change has been suggested as an essential component in the process of therapeutic change (Clarkin & Levy, 2004; Prochaska & Norcross, 2003). Furthermore, it has been maintained that searching for meaning and self-understanding is a way in which a survivor may facilitate the resolution of the abuse experience (Draucker, 1992). A survivor's desire to explore how his experiences of abuse have manifested in his adult behaviors, self-perceptions, and emotions can be important in the healing process.

Another important finding of this study is that male survivors sought counselling for a number of reasons not directly nor solely associated with sexual abuse. Instead, participants identified seeking therapy to deal with issues related to a negative sense of self, emotional processes, interpersonal difficulties, and self-awareness. Results highlight how male survivors often attend counselling to work on the many aftereffects of CSA. In fact, participants reported that they sought counselling with the intention of working on

issues unrelated to their history of CSA. However, as a result of engaging in therapy, issues linked to CSA inadvertently came to the surface. Male survivors experience extreme shame, fear, and insecurity related to their CSA, which often results in a hesitancy to seeking counselling for abuse issues (Dale et al., 1998; Draucker, 1992; Gartner, 1999; Ray, 2001). It is probable that male survivors engage in counselling for issues that seem "safer" to deal with as a way of psychologically protecting themselves (Gartner, 1999). The findings of this study identify many reasons for male survivors seeking therapy, rather than the abuse itself.

Previous research investigating the motivating factors for male survivors seeking counselling have concluded that male survivors tend to seek counselling for issues such as depression, anxiety, addictions, suicidal ideations, and interpersonal difficulties (Gill & Tutty, 1999; Ray, 2001). The results of this present study highlight the need for clinicians to note that many male survivors seek counselling for issues which may seemingly appear unrelated to CSA. While male survivors may present with a multitude of clinical concerns, the potential underlying issue of CSA merits therapeutic attention. In order for therapists to be effective in working with male survivors, it is important that they are not only aware of the many effects of CSA, but are also cognizant of the how these issues may manifest in therapy. Furthermore, understanding that disclosure of sexual abuse is often difficult for male survivors, and may not even occur in counselling, is vital (Hill et al., 1993). Gaining an appreciation of what motivates male survivors to seek counselling can be extremely helpful in the therapeutic assessment process, as well as developing a suitable treatment plan.

Helpful Counselling Experiences

The helpful ingredients identified in this study serve to broaden our understanding of the psychotherapy process with male survivors. The themes rendered in this study support the well documented importance of a therapist's interpersonal style and the overall therapeutic relationship (Bolton et al., 1989; Gartner, 1999; Mezey & King, 2000; Paulson et al., 1999; Sanderson, 1995). Particular Therapist interventions and the opportunity to engage in emotional expression in therapy were highlighted as helpful counselling elements. The benefit of exploring a client's internal strengths, emotional processes, and self-awareness was identified as an agent of helpfulness in therapy. While the idea of client growth and awareness has been found in other clinical populations, male survivors appear to have a particular perspective of what they consider helpful in this area.

Client growth and awareness. Of all the thematic clusters on the helpful counselling processes generated in this study, it appears that the theme of client growth and awareness has some unique nuances. Client growth and awareness refers to participants' desire to gain an understanding of their triggers, feelings of anxiety, and interpersonal relationships. As a result of counselling, participants also reported experiencing enhanced self-awareness, recognition of personal strengths, and their ability to trust in others. Findings suggest that male survivors find engaging in self-reflection as helpful in making sense and dealing with their CSA. Hanna and Ritchie (1995) found that insight and new understanding was perceived by clients as the most potent common change factor. From an integrative perspective, Frank (1987) considered successful

psychotherapy to be characteristic of its ability to alter the meaning a client attributes to their experiences.

Previous investigators have conceptualized client growth as "learning something" (Elliot & James, 1989), as a process of asking and answering questions (Wilcox-Matthew et al., 1997), or gaining knowledge in terms of acquiring new information or interpersonal skills (Paulson et al., 1999). In the current study, the cluster pertaining to client growth appears to be characteristic of participants' enhanced self-awareness, connection to inner strengths, and understanding of emotional processes. Not only was client growth and awareness considered a helpful aspect of counselling, participants also identified self-exploration and self-understanding as a motivating factor in initially seeking counselling. A connection appears to exist between male survivors' initial motives in seeking counselling and what they found helpful as a result of therapy.

Positive therapeutic relationship. The thematic cluster referring to the positive therapeutic relationship emerged as a notably helpful aspect of the counselling process. Participants identified that feeling supported, comfortable, understood, validated, respected, and believed was helpful. Experiencing a supportive therapeutic relationship based on trust, acceptance, and validation can be extremely helpful for male survivors who often enter counselling with anxiety and trepidation. A positive counselling relationship is vital in creating a safe foundation in which a male survivor can explore his confusion, shame, guilt, and emotional pain (Bolton et al., 1989; Gartner, 1999; Sanderson, 1995). Recovery from trauma associated with CSA is more likely to occur within the content of a relationship, regenerating the basic capacity for trust, autonomy, intimacy, and identity that was shattered as a result of the abuse (Herman, 1997).

The value of a positive therapeutic relationship has been recognized by adherents of practically all psychotherapeutic orientations (Garfield, 1995; Hovarth & Symonds, 1991; Orlinsky et al., 2004). Furthermore, the quality of the relationship has been acknowledged as one of the largest contributor to psychotherapy outcome (Lambert & Cattani-Thompson, 1996; Miller et al., 1995). While the therapist's perceptions of the therapeutic relationship can be informative, it is the client's experience of the relationship that is most predictive of outcome and is conducive to change (Greenberg & Watson, 1998; Woolfe, Dryden, & Strawbridge, 2003).

As the quality of the counselling relationship is important, researchers have explored the particular impact of the therapeutic relationship on survivors of CSA (Bolton et al., 1989; Gartner, 1999; Mezey & King, 2000; Sanderson, 1995). Armstrong (1989) reported that female survivors perceived validation, advocacy, empathetic understanding, and absence of contempt, punishment, and derision as helpful qualities of the counselling process. In many ways the therapeutic relationship can act as the first and perhaps primary vehicle in which a survivor can self-disclose, feel understood, validated, safe, engage in self-exploration, and able to repair and build interpersonal skills (Beutler & Hill, 1992; Carver et al., 1989; Dorais, 2002; Druacker, 1992; Gartner, 1999; Herman, 1995; Wheeler et al., 1992). Participants in this study clearly acknowledged how having a supportive therapeutic relationship was helpful in dealing with the many issues associated with CSA.

Therapist interpersonal qualities. A therapist's interpersonal style and general way of relating to a client can play an important role within the therapeutic environment. Participants identified therapists' ability to convey compassion, patience, empathy,

acceptance, reassurance, and ability to listen as helpful agents in counselling. Literature indicating the benefit of a therapist's interpersonal qualities has long been acknowledged in psychotherapy research (Elliot, 1985; Elliot & James, 1989; Paulson et al., 1999; Wilcox-Matthew et al., 1997). Additionally, a therapist's interpersonal style or qualities have been associated with a positive therapeutic outcome (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble, & Wong, 2004). Findings of the current study highlight the significance of a therapist's ability to communicate and interact with a survivor in a manner that promotes a sense of comfort and safety. The creation of a sense of safety for the survivor is one of the foundational steps in therapy (Herman, 1997). It appears that a therapist's interpersonal qualities, including compassion, patience, respect, and empathy are the building blocks needed for survivors to begin in their journey of healing within counselling.

Therapeutic interventions. Therapist interventions have been defined as the formal and/or deliberate therapist responses (Orlinsky et al., 2004). Male survivors in this study perceived a therapist's ability to provide insight, challenge thoughts, and supply information on sexual abuse and the general counselling process as helpful. These interventions have been cited as important elements to foster within therapy (Dorais, 2002; Gartner, 1999; Sanderson, 1995). This thematic cluster captures the benefit of therapists addressing the many preconceptions surrounding CSA, which resulted in the relinquishment of survivors' feelings of being at fault and alone in their pain. Researchers emphasize the significance of confronting distorted thought patterns, which are often held by survivors of CSA (Harrison, 2001; Lisak, 2001; Margolin, 1999; Wilken, 2003).

Dispelling preconceptions about sexual abuse can lead to cognitive restructuring and a sense of empowerment (Gartner, 1999).

Employing therapeutic interventions aimed at addressing recurrent questions and themes in therapy have been identified as especially helpful for male survivors in the current study. The thematic cluster referring to therapist intervention appears to be consistent with existing therapy process literature (Elliot 1985; Elliot & James 1989; Lietaer, 1992; Orlinsky et al., 2004; Paulson et al., 1999; Wilcox-Matthew et al., 1997). Wilcox-Matthew et al., (1997) reported that the therapists' responses, questions, challenges, and reframes are fundamental to the therapeutic change process. Additionally, Lietaer (1992) identified that specific therapist interventions, including feedback and confrontation were regarded as helpful processes in therapy.

Emotional expression. The thematic cluster of emotional expression refers to the participants' ability to experience, identify, and express emotions within therapy. Research findings have clearly acknowledged the value of emotional expression (Bolton et al., 1989; Draucker, 1992; Greenberg & Korman, 1993; Greenberg & Safran, 1989; Paivio & Nieuwenhuis, 2001; Saunders, 1999). Working with emotions in counselling can provide the client with important information which can promote understanding and therapeutic change (Greenberg & Safran, 1989; Paulson & Worth, 2002). Saunders (1999) has contended that a client's in-session emotional state is related to session quality and treatment effectiveness. Further research has suggested that experiential therapy, which focuses on the central role of emotional distress, has been effective for adult survivors of CSA (Paivio & Nieuwenhuis, 2001).

Existing literature emphasizes the importance of emotional expression, as it promotes survivor empowerment and reconnection (Bolton et al., 1989; Dorais, 2002; Draucker, 1992; Gartner 1999; Herman 1997; Lisak, 2001; Sanderson, 1995). Exploring the emotional scars of CSA can encourage the survivor to reconstruct and re-experience their traumatic past in the context of a safe therapeutic environment (Herman, 1997). Reconnection to the core emotions of a survivor is important and has been identified as a helpful component in the counselling process.

The helpful therapeutic aspects identified by participants in this present study are in accordance to those elements indicated by Lietaer (1992). Specifically, the clusters reflecting therapist interpersonal qualities and a positive therapeutic relationship are parallel to Lietaer's category of aspects of the relational climate. Furthermore, the thematic cluster of therapist interventions appears to be highly similar to specific therapist interventions. The clusters of emotional expression and client growth seem to coincide with process aspects concerning the client identified by Lietaer (1992).

The thematic cluster of therapist interpersonal qualities is comparable to the findings of counsellor facilitative interpersonal style, whereas the theme of positive therapeutic relationship is comparable to client self-disclosure (Paulson et al., 1999). Interestingly, therapist intervention is akin to the clusters of counsellor intervention and generating client resources. The theme encompassing emotional expression is one that has an evident link to the cluster of emotional relief. Although the thematic cluster of client growth is somewhat related to new perspective and gaining knowledge, they are not completely similar, as participants in the current study emphasized the aspect of self-

reflection. The categories of accessibility and client resolutions were the only clusters not identified in the current study.

Unhelpful Counselling Experiences

Male survivors' perceptions of unhelpful processes in therapy revealed the need for survivors to experience therapist receptiveness, effective counselling interventions, therapeutic attunement, and a positive therapeutic relationship. While participants' responses on the unhelpful aspects of the counselling process echo some of the previous work done in this area, the results also highlight specific unhelpful elements as perceived by male survivors. A lack of therapeutic preparation was identified as an especially unhelpful or hindering aspect of the counselling process.

Lack of therapeutic preparation. The thematic cluster referring to the Lack of Therapeutic Preparation is a unique finding not previously reported in the literature. Participants indicated the importance of several preparatory components, including the establishment of a support system, reassurance, and education on issues related to CSA. In comparison to the existing literature, the aspect of therapeutic preparation is a particularly new category. Although this theme is somewhat comparable to Paulson et al.'s (2001) uncertain expectations, there is a distinctive element in this cluster, which clearly refers to male survivors' need to feel supported, reassured, and knowledgeable about CSA. Preparing a survivor for counselling and ensuring a sense of safety and assurance can facilitate a meaningful and fruitful therapeutic experience (Sanderson, 1995).

The establishment of a support system outside of therapy was identified as a precondition for delving into issues related to CSA. The lack of such preparation was

regarded by participants as an unhelpful counselling process. The creation and maintenance of a support system outside of therapy is an important element from the very beginning of therapy, throughout the healing process, and particularly when the survivor feels ready to terminate therapy (Sanderson, 1995). Bankoff (1996) has identified the potentially powerful role of network support as effective input into the psychotherapeutic process. Strong and reliable support systems can provide the survivor with much needed grounding, encouragement, and reassurance (Gartner, 1999). Participants reported that having a network of supportive friends and family served as a safety net from which they could venture but always return to.

The cluster referring to a lack of therapeutic preparation also speaks to the need for therapists to provide clients with reassurance that they will survive what they are experiencing. Margolin (1999) emphasizes the necessity for treatment to empower the client and for the therapist to communicate the belief in the individual's ability to grow and change. While the theme of reassurance speaks to a male survivor's need for a therapist to validate his experiences of confusion, despair, and emotional pain, it also conveys the possibility of change and healing. A therapist's ability to highlight that a survivor has the capacity to deal with his scars can be extremely helpful, and engender a sense of hope (Sanderson, 1995). The absence of such reassurance can be perceived as an unhelpful counselling element.

A lack of education provided to the survivor by the therapist in counselling was reported to be an unhelpful factor inherent in the theme of therapeutic preparedness. Participants indicated a desire to gain knowledge about the common experiences of male survivors and to be provided with information on their treatment options. Educating the

survivor as a part of therapy preparation serves to normalize and increase the survivor's awareness about their experience(s) of sexual abuse (Sanderson, 1995). It is important for a survivor to be provided with information on the various aftereffects of childhood sexual abuse and the potential recovery issues (Dorais, 2002; Gartner, 1999; Harrison, 2001; Sanderson, 1995; Wilken, 2003). As a result of exploring issues related to CSA, male survivors can acknowledge that they are not alone in what they have experienced. By incorporating an element of client education in counselling, survivors are able to understand their past, what they are currently experiencing, and what they can expect in the future. It is possible that the lack of education on CSA can perpetuate client confusion; thus, contributing to a negative therapeutic experience.

Therapist receptiveness. A therapists' responsiveness in therapy has been identified as an important element (Stiles, Honon-Webb, & Surko, 1998). The thematic cluster referring to therapist receptiveness reflects participant perceptions of therapist judgment and blame. A lack of therapist receptiveness in conveying validation and empathy, appeared to result in the participants feeling responsible for their CSA. A study by Armstrong (1989) reported that negative, blameful, and rejecting therapist responses were reported to be harmful therapist practices. Positive therapist receptiveness can guard against fueling or recapitulating the messages of blame the survivor has received or has engendered for themselves (Armstrong, 1989; Sanderson, 1995).

In blaming and judging the client in relation to their CSA, the therapist fails to validate the clients' experiences. The importance of validating a client's experience of CSA has been identified as an extremely crucial therapeutic element (Armstrong, 1989; Gartner, 1999; Sanderson, 1995). Researchers have spoken to the significance of

validation, as survivors are often hypervigilant to any slight indication that they are not believed or are being judged (Draucker, 1992; Gartner 1999; Herman, 1997; Sanderson, 1995). Although therapist responsiveness has been described as facilitating positive and reciprocal therapeutic communication (Stiles et al. 1998), participants in this study identified receptiveness as a function of therapists' invalidating responses to their experiences of CSA.

Ineffective therapeutic intervention. Therapeutic approaches which did not incorporate collaborative and directive elements were reported to be unhelpful in the counselling process. Participants also highlighted the desire for therapy to be in the "here and now" and emotion focused. Previous research has identified the therapeutic value of therapist feedback and directiveness (Lietaer, 1992), as well as the benefit of a collaborative working environment (Gartner, 1999). Essentially, this thematic cluster is indicative of the negative aspects of ineffective counselling approaches that fail to meet the participants' particular needs. According to Silberschatz and Curtis (1993) when a therapeutic intervention is in accord with the client's needs and goals for therapy, the client will likely show signs of improvement. It appears that if a male survivor does not experience appropriate counselling interventions, therapy may be unhelpful and could potentially harm the healing process.

Lack of therapeutic attunement. Participants perceived a lack of therapeutic attunement as an unhelpful element of their counselling experience. Attunement refers to the need for a therapist to pace with the client, as well as for therapy to be individualized, and flexible. The importance of these ingredients in therapy has been documented in the research literature (Gartner, 1999; Gold & Cherry, 1997; Harrison & Morris, 2001;

Mannon & Leitschuh, 2002; Margolin, 1999; Nurcombe et al., 2000, Sanderson, 1995). Research highlights the need for therapy to be paced according to the clients' rhythm, in order to modulate the client's emotional intensity throughout treatment (Briere, 1989). Sanderson (1995) has contended that it is essential to be mindful of timing and pacing as therapists need to remain sensitive and alert to the survivors' level of psychological processing. A lack of therapeutic pacing can have detrimental effects on a survivor if they are unable to cope with the emotionally charged material associated with their abuse (Sanderson 1995).

Given that there is no therapeutic approach of choice for survivors of CSA, researchers have proposed that counselling needs to tailored to each individual client (Harrison & Morris, 2001; Mannon & Leitschuh, 2002; Margolin, 1999; Nurcombe et al., 2000, Sanderson, 1995). The thematic cluster referring to a lack of therapeutic attunement captures the importance of individualized treatment for male survivors. Participants clearly indicated a need to have counselling meet their particular needs. The absence of an individually tailored therapeutic experience was perceived to be unhelpful. As some survivors will find certain therapeutic approaches more helpful than others, a therapist needs to be open to implementing a variety of counselling methods (Dorias, 2002; Gartner, 1999; Harrison, 2001; Margolin, 1999; Mezey & King, 2000; Price et al., 2001; Sanderson, 1995). When counselling is geared to meet the specific needs of the individual client, therapy is more likely to be helpful (Silberschatz and Curtis, 1993)

Within the thematic cluster referring to lack of therapeutic attunement, participants also identified the importance of flexibility in the therapists' approach to

counselling. Gold & Cherry (1997) have emphasized the need for flexibility and the counter-therapeutic effects of inflexibility in therapy:

> The automatic imposition of a preconceived structure on the client with the assumption that the same set of guidelines will be effective for all is likely to obscure rather than promote understanding of and empathy for the individual client and his or her unique situation and needs (p. 150).

In disregarding and not responding to clients' needs for a flexible counselling approach, client growth may be hindered. The importance of therapeutic flexibility appears to be relevant across client populations (Gold & Cherry, 1997). The findings from the current study support the existing literature, as male survivors also indicate the need for therapy to be flexible, individualized, and sensitively paced.

Negative therapeutic relationship. The therapeutic relationship is frequently seen as a potent agent for change for adult survivors of CSA (Gartner, 1999). A positive therapeutic relationship has not only been found to be helpful in therapy (Prochaska & Norcross, 2003), but has also been regarded as the primary element in counselling survivors (Herman, 1997). Conversely, a negative therapeutic relationship has been viewed as detrimental to a survivor of CSA (Harrison, 2001). Participants identified how a negative therapeutic relationship lacking trust, empathy, openness, and respect was unhelpful in the counselling process. The therapeutic relationship has been said to serve as the foundation in where the survivor can initially build a sense of trust with the therapist that can then translate to other relationships (Draucker, 1992). Hegeman (1995) has strongly purported the need for therapy to revive the client's capacity for a positive relationship in order to allow the therapeutic dyad to be the vehicle in which the abuse can be dealt with. Therapy without a strong therapeutic relationship can be at a stalemate (Paulson et al., 2001) and can hinder the facilitation of safety and client growth.

Overall, the concept map reflecting participants' perceptions of unhelpful experiences in counselling is relatively consistent to the findings in past research. The themes generated in this present study are akin to a few particular clusters illustrating unhelpful counselling events found by Elliot (1985). Therapist receptiveness is parallel to the cluster of negative counsellor reaction. Furthermore, the theme referring to a lack of therapeutic attunement relates to Elliot's (1985) categories of misperception and misdirection, whereas, the cluster of ineffective therapeutic intervention can be best subsumed under repetition, unwanted responsibility, and unwanted thoughts.

The unhelpful themes identified by participants in the current study are also in accordance with Lietear's work (1992) examining the hindering processes in therapy. Interestingly, the thematic clusters of therapist receptiveness, ineffective therapeutic intervention, lack of therapeutic attunement, insufficient therapeutic preparation, and negative therapeutic relationship appear to be similar to one of the three main hindering categories identified by Lietaer (1992). Specifically, it seems that the unhelpful elements described by the participants are subsumed under the category of attitudes and interventions of the therapist. When examining findings reflecting the unhelpful ingredients of counselling, it is evident that participants identified aspects that were mainly focused on the therapist or general therapeutic process, rather than any client processes as found in Lietaer's work (1992). In particular, participants in this study seemed to have attributed unhelpful experiences in counselling to an outward source, and did not indicate how they may have contributed to the therapeutic processes.

The thematic clusters generated on unhelpful counselling experiences are also related to the study by Paulson et al., (2001). The theme of therapist receptiveness is

parallel to Paulson et al.'s (2001) Lack of Responsiveness. Additionally, the cluster of negative therapeutic relationship is akin to that of negative counsellor behaviors and barriers to feeling understood. The theme of lack of therapeutic attunement is similar to the cluster of lack of connection, whereas the category of ineffective therapeutic intervention is concordant to the cluster of insufficient counsellor directiveness. The thematic cluster referring to concerns about vulnerability, uncertain expectations, lack of commitment and motivation, and structure of counselling were not identified in the current study.

Conclusion

The results of this study shed light on adult male survivors' counselling experiences. Exploring the motivating factors involved in male survivors seeking therapy has revealed that survivors often seek therapy with a vast array of presenting issues that may initially appear unrelated to abuse. It appears that the distressing symptomatic aftereffects of the abuse compelled survivors to get help, rather than CSA itself. Difficulties relating to emotional processes and interpersonal relationships were indicated to be motivating forces in engaging in therapy. In addition, male survivors' negative self-feelings and a desire to understand and explore the complexities inherent in healing from CSA were identified as reasons for pursuing counselling. Overall, the findings poignantly illustrate that male survivors tend to seek therapy for issues that may not at first be explicitly related to a history of CSA.

Exploring a male survivor's internal strengths, emotional processes, and self-conceptions was identified as especially helpful. Although the themes of client growth and awareness have been previously studied, male survivors in this study experience self-

reflection and understanding as a valuable counselling process. Additionally, male survivors revealed that a positive therapeutic relationship characteristic of support, understanding, acceptance, and trust was highly helpful. Therapist qualities engendering respect, compassion, patience, and empathy were identified as being beneficial in therapy. The foundational elements inherent in a positive therapeutic relationship and facilitative therapist qualities provide the conditions necessary for effective interventions, emotional expression, and client growth. The helpful elements identified by the male survivors in this study are consistent with those researched in other clinical populations (Dale et al., 1998: Elliot & James, 1989; Lietaer, 1992; Paulson et al., 2001; Paulson & Worth, 2002).

While there are notable parallels between what male survivors and other clinical populations find helpful in therapy, there are certain unhelpful aspects of counselling which merit particular attention when working with male survivors. A new finding that adds to our understanding of working with male survivors is the need for clients to feel prepared for therapy. Participants indicated that having a support system and reassurance in their ability to heal was necessary and the lack of these elements was experienced as unhelpful. Moreover, the need for education on CSA was emphasized as a critical component for both the client and therapist.

In examining what male survivors perceived to be unhelpful in therapy, it is clear that what many participants experienced in counselling contradicts what has been established as effective therapeutic approaches when working with survivors (Armstrong, 1989; Harrison, 2001). Participants identified that feeling blamed, judged, disrespected by their therapist was unhelpful and not conducive to the development of a positive

therapeutic relationship. Additionally, a need for therapeutic pacing, flexibility, and individual treatment was reported. It is evident that the results of this study provide much needed information for clinicians working with male survivors.

Study Limitations

While this study offers insight into the therapy process with male survivors of CSA, there are several limitations that merit attention. A weakness of the study is its reliance on self-reporting and its retrospective nature. Given that participants' responses are based on recalling their past experiences of motivations in seeking counselling, as well as what they found helpful and unhelpful in therapy, these descriptions are subject to distortions. Participant reports may be influenced as a result of forgetting information, biased interpretations and beliefs, and self-representation style. Additionally, participants responded based on their current perceptions rather than on their understanding of the counselling process at the actual time of therapy.

An additional limitation of the study is related to the participant sample. Essentially, participants volunteered to take part in the study. Research has found that participants who volunteer are likely to be a biased sample of the target population (Gall, Gall & Borg, 2003). A large portion of the male survivors who participated in this study shared particular characteristics (i.e., education level, ethnic background, and service provider) that are not entirely representative of this clinical population as a whole. Efforts to minimize this effect were taken and included advertising in a variety of counselling agencies, newspapers, as well as placing an advertisement on a widely viewed television program.

Despite the researcher's attempt in tailoring the research questions to elicit participants' perspectives without overly constraining their responses, it is possible that descriptions were influenced by the comments made by the researcher during the interview. Although considerable effort was made to avoid influencing participants' reflections, it is plausible that client responses were affected by the researcher's remarks.

A notable limitation of this research study involves the exclusion of the rating procedure commonly utilized in the concept mapping approach. Given the large number of statements to be sorted, researchers were aware of the potential for participant fatigue. Although the results of the study illustrate the underlying structure of how male survivors perceive the counselling process, the relative importance of their responses is unknown due to the lack of the ratings questionnaire.

Implications for Counselling

The findings of this study have clinical implications for the treatment of male survivors of CSA. Given that male survivor may not seek therapy for issues directly related to CSA, it is important for therapists to be aware of the potential underlying dynamics at the root of the issues presented in counselling. Many survivors who do engage in therapy do not disclose a history of CSA (Hill et al., 1993). Therefore, it is crucial for therapists to be respectful and understanding of clients' boundaries and difficulties in disclosing their abuse. Additionally, clinicians need to consider and sensitively inquire about the possibility of a history of CSA when working with male clients.

While the aftereffects of CSA appear to manifest in therapy in a variety of ways, therapists need to be educated about the common experiences of male survivors. Existing

research emphasizes the importance for formal therapist training and education in working with male survivors, as it can greatly influence a therapist's effectiveness and facility (Bolton et al., 1989; Day et al., 2003; Dorais, 2002; Gartner, 1999; Herman, 1997; Margolin, 1999; Sanderson, 1995). The absence of adequate therapist training is likely to have detrimental consequences on the counselling process experienced by male survivors. Therapists who are specifically educated in working with survivors are less likely to inadvertently harm their client as a result of therapy (Day et al., 2003).

Another implication of this study for the treatment of CSA is that it highlights the important features of the therapeutic relationship and a therapist's interpersonal style. Participants' responses offer guidance as to what is perceived to be effective and helpful in therapy: namely, a supportive, respective, patient, understanding, validating, accepting, and trust engendering therapeutic environment. Additionally, the importance of emotional experience and expression was a helpful aspect identified by male survivors in this study. Therapists working with male survivors need to be especially aware of the development of a solid working relationship that promotes safety, trust, and emotional exploration.

This study also serves to illustrate the negative impact of several unhelpful counselling processes. Findings emphasize the importance of a positive therapeutic environment that is characteristic of therapist responsiveness and attunement. In order for therapy to be beneficial for male survivors, clinicians need to be active in their communication of empathy, compassion, and receptiveness to client needs. As trust is often a fundamental element of a positive therapeutic climate, is it vital for clinicians to pay special attention in how trust can be developed and sustained throughout therapy.

The lack of therapeutic preparation was also highlighted by participants as an unhelpful aspect of counselling. As such, therapists need to ensure that a male survivor is informed of the counselling process, feels reassured, and has a support network outside of therapy. These preparatory elements could be incorporated early on into therapy so as to provide survivors with the foundational support needed in order for therapy to be most helpful.

Implications for Research

As the results of this study have offered insight into the counselling experiences of male survivors, a number of potential directions for future research exist. While the methodology of concept mapping capitalizes on qualitative data gathering procedures and quantitative analysis approaches, further qualitative work would be valuable. For instance, employing a phenomenological approach to this area of study would enhance our understanding in how male survivors ascribe meaning to the phenomenon which they experience. In particular, focusing on the three individual questions explored in this study would provide additional in-depth conceptualization of what motivates clients to seek counselling, as well as what they find helpful and unhelpful in therapy. Additionally, tracking client perspectives both during and after therapy could potentially extend psychotherapy process research with survivors.

Future research could seek to provide additional validation for the results of this study by designing a survey based on the statements generated by participants. Exploring the helpful and unhelpful aspects of counselling, as well as clients' motives in seeking therapy, would likely enhance treatment delivery and effectiveness. Also, surveying a

larger sample of male survivors, including younger and culturally diverse participants could broaden our understanding of therapy with this general client population.

Examining the relative importance and the long-term outcomes resulting from helpful and unhelpful experiences in counselling could be an additional way in which this study could be built upon. In particular, exploring the effects of helpful and/or unhelpful counselling experiences on future therapy seeking behavior and motives would be interesting and potentially fruitful.

The present study could also be expanded upon by the inclusion of client-therapist dyads. Although it is important to gain an understanding of the client's perceptions of counselling, it is likely that examining the therapist's experiences would greatly inform us in terms of the dynamics at work within the dyad. Moreover, considering the documented discrepancies in client and therapist perceptions, it would be beneficial to enhance our understanding of this phenomenon with the particular population of male survivors of CSA.

Concluding Remarks

In reviewing the literature on CSA, it becomes clear that the study of male survivors in counselling is a neglected area. In particular, research examining the male survivor's perspective on their counselling experience is incredibly under-studied. Thus, the main intent in undertaking this research project was to gain an appreciation of some of the therapeutic experiences male survivors experience in counselling. Understanding what male survivors perceive as helpful and unhelpful in therapy was a key objective. Considering that male survivors are less likely to seek counselling, another goal of this study was to explore some of the potential motivating factors for those survivors who do

engage in therapy. In enhancing our appreciation of how the counselling process is perceived by this particular clinical population, clinicians can as a result provide more effective therapeutic services. Once a male survivor's pain is acknowledged, respected, and heard within a positive therapeutic relationship – hope and healing can then become a possibility.

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Appendix A

Ethical Approval

RESEARCH ETHICS BOARD
(EE REB)

I. Application for Ethics Review of Proposed Research
(revised June 23/03)

Name: Sherry R. Antonucci **Student ID (if applicable):** #372271

E-mail: sr6@ualberta.ca

Complete mailing address (if student):

#301, 10308-114 Street
Edmonton, AB.
T5K 2X2

Project Title: The Counselling Experience of Adult Male Survivors of Sexual Abuse

Project Deadlines:
Starting date (year/month/date): 03/10/01 Ending date (year/month/date): 04/07/01
If your project will extend beyond the original ending date, you must submit a *Request for Change in Research Study*.

Annual Reporting
If your project extends beyond one year from the date of EE REB approval, you will be required to submit an annual status report at the end of each year of the project. Projects are normally subject to a complete re-submission after 3 years.

Status (if student):
( ) Master's Project (X) Master's Thesis ( ) Doctoral Dissertation ( ) Other (specify):

Funding (if applicable):
( ) Grant Application. ( ) Contract Research ( ) Non-Funded Research (X) Other (specify): Funded Research

Do you plan to gather data in University of Alberta units other than Education or Extension? Yes ( ) No (X)
If yes, name the unit(s) _____.

I, the applicant, agree to notify the Research Ethics Board in writing of any changes in research design, procedures, sample, etc. that arise after the EE REB approval has been granted. A *Request for Change in Research Study* form must receive approval from EE REB before the modified research can proceed.

I also agree to notify the EE REB immediately if any untoward or adverse event occurs during my research, and/or if data analysis or other review reveals undesirable outcomes for the participants.

I have read the University of Alberta Standards for the Protection of Human Research Participants [GFC Policy Manual, Section 66 [http://www.ualberta.ca/~unisecr/policy/sec66.html] and agree to comply with these Standards in conducting my research.

Sherry R. Antonucci — Signature of Applicant
September 16,03 — Date

As the supervisor/instructor, I have read and approve submission of this application to the EE REB, and ensure that the proposed project is compliant with the University of Alberta Standards for the Protection of Human Research Participants [GFC Policy Manual, Section 66 [http://www.ualberta.ca/~unisecr/policy/sec66.html]

Dr. Barbara Paulson — Printed name of Supervisor/Instructor
Barbara Paulson — Signature of Supervisor/Instructor
Sept 16/03 — Date

ETHICS REVIEW STATUS

(✓) Application approved by EE REB member ( ) Application approved by EE REB ( ) Application not approved

Signature of EE REB Member
Sept 22, 2003 — Date

Appendix B

Study Advertisement

RESEARCH STUDY!!!!

What has Counselling been like for you?

Hello my name is Sherry and I am a second year Master's student in Counselling Psychology at the University of Alberta. As a therapist in training, I am very interested in what clients find effective in therapy.

In the past, I have worked with a number of adult survivors of sexual abuse and I would like to further understand how the counselling process is experienced. In particular, I am interested in exploring what aspects of counselling make a difference in dealing with childhood sexual abuse, as perceived by *adult male survivors.*

Are you a male survivor of childhood sexual abuse/assault? Are you 18 or older? Have you had at least one session of *individual* counselling?

If so, and you would like to participate in a short study that would help us figure out how to best provide counselling services please contact Sherry at 454-9380 or sr6@ualberta.ca.

Participation is completely voluntary and your involvement in this study will be kept in the strictest of confidence.

Appendix C

Study Information Form

Research Project: **The Counselling Experience of Adult Male Survivors of Childhood Sexual Abuse**
Department of Educational Psychology
Education North
University of Alberta

Principle Researcher: Sherry R. Antonucci
Supervising Researcher: Dr. Barbara Paulson

The purpose of this study is to gather information on how the counselling process is experienced by adult male survivors of childhood sexual abuse/assault. In particular, we are interested in gaining an understanding of what aspects of individual counselling has helped in dealing with past sexual abuse/assault. It is hoped that this information will be helpful in developing more effective means of delivering counselling services to male survivors.

This study is divided into two parts. PART I involves the completion of a questionnaire, which is attached. PART II consists of sorting a series of themes generated by the questionnaire responses. Your involvement in this study will be kept confidential and your name will not be attached to the information that you give. In addition, none of your responses will be shared with your past treating therapist(s). As completing this survey is voluntary, your completion and return of this questionnaire will indicate that you have given your consent to participate in **PART I only.**

If you wish to participate in PART II, please contact Sherry R. Antonucci at 454-9380 or Dr. Barbara Paulson at 492-5298 or email us at sr6@ualberta.ca. You may accept or decline participating in either or both PART I and/or PART II at any time, without penalty.

It is recognized that that this topic may create discomfort for some participants. As such, a list of possible counselling agencies and support resources has been attached. The results of this study may be used for presentation at professional meetings and publication in journals of a professional nature.

Please return the completed questionnaire in the self-addressed envelope provided or by e-mail to sr6@ualberta.ca by February 1, 2003.

If you have any questions or concerns please contact Sherry R. Antonucci at 454-9380 or Dr. Barb Paulson at 492-5298.

Thank you for taking the time to complete this questionnaire.

Appendix D

Participant Demographics Form

GENERAL INFORMATION: PART I/II
Please complete the following as fully as possible.

What is your level of education?_____

In which of the following age ranges does your age fall?
_____ 18-25
_____ 26-35
_____ 36-44
_____ 45-54
_____ 55-64
_____ 65 or older

Marital Status:
_____ Single
_____ Married
_____ Common-Law
_____ Separated/Divorced

What is your ethnic background?_____

Approximately how many sessions of individual counselling have you received?_____

What concerns have you dealt with in individual counselling? _____
_____

What type of service provider have you had in individual counselling?
_____ Psychologist
_____ Psychiatrist
_____ Family Doctor
_____ Counsellor
_____ Minister
_____ Social Worker
_____ Other (please specify)_____

Have you experienced a single_____ or ongoing incident_____of childhood sexual abuse? Please check one?

What was your relationship with the person (s) that sexually abused/assaulted you?_____
_____

PLEASE FLIP THE PAGE ⟶

In which of the following age ranges does the person(s) that sexually abused/assaulted you fall (i.e., at the time of the abuse assault)?

_____ 17 or younger
_____ 18-25
_____ 26-35
_____ 36-44
_____ 45-54
_____ 55-64
_____ 65 or older

What was the gender of the person(s) who sexually abused you?
_____ Male
_____ Female
_____ Both

Thank you for participating in PART I of this study. If you wish to participate in PART II, please contact Sherry R. Antonucci at 454-9380 or Dr. Barbara Paulson at 492-5298 or email us at sr6@ualberta.ca.

Appendix E

Questionnaire

PART I

Please reflect on the following questions in as much *detail as possible*. There are *no right or wrong* answers. *Please do not identify your past treating therapist(s).* If you require more writing space, please refer to the attached blank pages.

1. **What motivated you to seek counselling?**_____

2. **What aspects of counselling made a positive difference in dealing with your childhood sexual abuse?**_____

3. **What would you change about your counselling experience?** _____

Appendix F

Sorting Consent Form

PART II **ID. No____**

Consent Form

Research Project: **The Counselling Experience of Adult Male Survivors of Childhood Sexual Abuse**
Department of Educational Psychology
Education North
University of Alberta

Principle Researcher: Sherry R. Antonucci
Supervising Researcher: Dr. Barbara Paulson

The purpose of this study is to gather information on how the counselling process is experienced by adult male survivors of childhood sexual abuse. In particular, we are interested in gaining an understanding of what aspects of counselling has helped in dealing with past sexual abuse. It is hoped that this information will be helpful in developing more effective means of delivering counselling services to male survivors.

This study has been divided into two parts. PART I involved the completion of a questionnaire. PART II consists of sorting a series of themes generated by the questionnaire responses. Your involvement in this study will be kept confidential and your name will not be attached to the information that you give. You may accept or decline participation at any time, without penalty.

It is recognized that that this topic may create discomfort for some participants. As such, a list of possible counselling agencies and support resources will be provided. The results of this study may be used for presentation at professional meetings and publication in journals of a professional nature.

I give my informed consent to participate in <u>PART II</u> of this study. I have an understanding of the nature and purpose of this project. I understand I have the right to withdraw at any time and that my anonymity and confidentiality will be maintained.

_____ _____
Name of Participant Date

_____ _____
Name of Researcher Date

Appendix G

Sorting Instructions

INSTRUCTIONS FOR PART II

READ THROUGH THE SET OF STATEMENTS AND SORT THESE CONCEPTS INTO PILES IN A WAY THAT MAKES SENSE TO YOU. YOU ARE TO PLACE SIMILAR STATEMENTS TOGETHER INTO THE SAME PILE (YOU ARE GROUPING FOR SIMILARITY, NOT PRIORITIZING). YOU MAY HAVE AS MANY PILES AS YOU WISH – EXCEPT THAT YOU CAN'T HAVE ONLY ONE PILE. IF YOU BELIEVE THAT A STATEMENT IS UNRELATED TO ALL OF THE OTHERS, YOU CAN PLACE IT ALONE IN ITS OWN PILE. THERE ARE NO RIGHT OR WRONG GROUPINGS. YOU MAY FIND THAT YOU COULD PILE THE STATEMENTS IN SEVERAL WAYS. YOU ARE TO CHOOSE THE WAY WHICH SEEMS TO FIT FOR YOU.

WHEN YOU ARE FINISHED, STAPLE EACH PILE TOGETHER AND PLACE ALL OF YOUR PILES IN THE WHITE ENVELOPE LABELED "PART B", SEAL IT AND RETURN IT IN THE BROWN ENVELOPE PROVIDED.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RESEARCHER FOR ASSISTANCE.

THANK YOU.

Appendix H

Participant Referral List

Given the sensitive nature of this topic you have reflected on, the following is a list of referral counselling services and agencies in the case you wish to speak to someone for support.

Sexual Assault Centre of Edmonton	**423-4121**
Sexual Assault Centre, University of Alberta	**492-9771**
Clinical Services, University of Alberta	**492-3746**
The Family Centre	**423-2831**
Cornerstone Counselling	**482-6215**
Catholic Social Services	**432-1137**
Distress Line	**482-HELP (4357)**
Jewish Family Services	**454-1194**